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MEDICARE PAYMENT POLICIES FOR POST-ACUTE CARE

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BEFORE THE

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UNITED STATES SENATE

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COMMUNICATIONS

MEDICARE PAYMENT POLICIES FOR POST-ACUTE CARE

WEDNESDAY, APRIL 9, 1997

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to recess, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, D'Amato, Rockefeller, Bryan, and Kerrey.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order. I am pleased to welcome all of you to today's hearing on Medicare post-acute care payment policies. In our rapidly evolving health care system, Medicare reimbursement for post-acute care services is antiquated. Medicare pays the reasonable cost of post-acute care after services are delivered.

During 1995, both President Clinton and the Congress proposed policy changes establishing new prospective payment systems for home health care and skilled nursing care. Unlike a prospective payment system which provides a limited predetermined amount for caring for a patient, cost-based reimbursement does not encourage efficiency and instead has helped fuel tremendous growth in spending.

Incentives have emerged for post-acute care providers to increase the volume of services they provide with less administrative oversight. The concerns about quality of care and possible fraud have also increased.

Post-acute care services are furnished by skilled nursing facilities, home health agencies, rehabilitation facilities, and long-term care hospitals. Although services furnished by these providers frequently follow a hospital stay, in some cases patients can be admitted directly to a rehabilitation facility or long-term care hospital. In addition, home health care services are predominantly provided to beneficiaries who did not have a previous hospital stay.

During the 1970's, Medicare was primarily an acute care program that paid for hospital physician services and relatively little care for people with more chronic conditions. Over the past 15

years, Medicare spending has shifted increasingly to post-acute care services.

In fact, post-acute care services represent the most rapidly growing component of fee-for-service spending. From 1990 to 1995, Medicare's spending on post-acute care grew by a 30 percent average annual rate.

Total of post-acute care spending grew from about $8 billion to $30 billion over the same 5-year period. This kind of growth is just not sustainable. The future of Medicare fiscal integrity relies a great deal on our ability to understand how we can best address post-acute care services.

Today we will hear from two panels. The first panel includes representatives from the General Accounting Office and from the Congressional Budget Office who will discuss the history and current trends in post-acute care services. They will examine the economic incentives inherent in current law and under proposed reforms.

For further comment, we will then turn to a second panel representing providers of post-acute care services.

Senator Rockefeller, would you care to make any comment?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. Just a word. As you indicated, between 1990 and 1995 Part A spending on post-acute care services went up 28.8 percent per year over 5 years. That was compared to about 10 to 10.5 percent for all Medicare benefits, and 6 percent for acute care hospital services that were under the prospective payment system. So, as you indicate, this is not sustainable and our panels this morning will help us understand this. Thank you.

The CHAIRMAN. Thank you very much, Senator Rockefeller.

Our first panel will begin with Dr. William Scanlon, who is director of Health Financing and System issues of the GAO. He will be followed by Dr. Joseph Antos, assistant director of Health and Human Services at the Congressional Budget Office. We are also pleased to welcome Mr. Dowdal. Welcome. Gentlemen, it's nice to have you here.

Dr. Scanlon, do you want to begin?

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY THOMAS DOWDAL, SENIOR ASSISTANT DIRECTOR

Dr. SCANLON. Thank you, Mr. Chairman and members of the committee. We are very pleased to be here today to discuss Medicare's post-acute care benefits, specifically those for skilled nursing facilities, home health care, inpatient rehabilitation, long-term care hospitals, and the administration's legislative proposals related to them. All types of post-acute care have been growing rapidly in the 1990's and the driving force behind that growth has been more use of each type of benefit.

A combination of factors led to the increased use, including changes in law and guidelines that liberalized coverage of services, growing numbers of providers that increased the supply of services

available, acute care hospitals' incentives to discharge patients earlier, and a diminution of administrative controls which made it less likely that inappropriate claims would be identified and denied.

SNF and home health care comprised the bulk of post-acute care services and, in order to limit my oral statement I will focus on those, though in our written testimony we have discussed all of the types of post-acute care.

SNF and home health care account for 85 percent of post-acute care expenditures and after relatively modest growth during the 1980's, spending on both grew very rapidly in the 1990's, averaging 22 percent for skilled nursing facilities and 33 percent for home health agencies.

As this chart here indicates for home health agencies, there was rapid growth that was partially associated with very significant policy changes that affected the availability and use of these services. A similar chart is in our written testimony with respect to skilled nursing facilities and shows a very similar type of relationship.

The two changes in terms of policy that triggered the increase in growth in both of these benefits were the reissuance of the coverage guidelines for skilled nursing facilities that occurred in 1988, and for home health care that occurred in 1989.

These reissuances of the guidelines were the esult of court cases that HCFA settled after having been relatively restrictive in terms of the review of claims before that time period, and the result has been the type of growth that we have seen here.

We had expected, with the implementation of Medicare inpatient prospective payment for hospitals in 1983, that the utilization of skilled nursing facility and home health benefits would grow fast as hospitals discharged patients earlier.

However, HCFA's relatively stringent interpretation of coverage and eligibility criteria held that growth in check for the next few years. It was only with the court cases and the reissuance of the guidelines that we saw the benefits increase dramatically.

HCFA's 1989 guidelines have also dramatically changed the home health benefit from one focused on patients needing short-term care after a hospital stay to one that serves chronic, long-term care patients as well.

As the number of beneficiaries receiving home health care more than doubled since 1989 to reaching almost 4 million, the portion of beneficiaries receiving more than 90 visits tripled from 6 to 18 percent of beneficiaries using the service, demonstrating the program's increasing role in serving longer-term patients.

Increased utilization also accounted for much of the growth in the skilled nursing facility spending, as users of the service also doubled between 1989 and 1996. However, increases in Medicare's payments per day also contributed substantially to spending.

These increases were fueled primarily by greater use of ancillary services such as physical and occupational therapy. Costs of these services grew three times as fast as routine skilled nursing facility costs for nursing, room and board.

Notably, ancillary costs are not subject to limits. Instead, ancillary services are subject to medical necessity criteria, and relatively little review of their use is conducted by Medicare.

Another factor contributing to both the growth in skilled nursing facility and rehabilitation facility use is the substitution of days of care in these settings for what, in the past, would have been the last few days of an acute care hospital stay.

The number of hospitals operating their own skilled nursing facility or rehabilitation unit has increased dramatically. Operating these units facilitates a hospital increasing its Medicare revenues by transferring patients as soon as possible to their skilled nursing facility or rehabilitation unit. They then receive the full inpatient hospital prospective payment and the cost-based payments for the days spent in the post-acute unit.

Among the major proposals in the administration's fiscal 1998 budget are plans to develop prospective payment systems for skilled nursing facilities and home health care to gain better control of expenditures in the short term and a comprehensive payment system for post-acute care in the longer term.

While prospective payment encourages control of costs, it's important in designing such systems to be mindful of the incentives created regarding the quantity and quality of services providers will deliver.

Selection of a unit of service for payment and taking account of varying needs of patients for different types of services are important aspects of the design because of the incentives they create. Moreover, implementation of prospective payment needs to be complemented by adequate investment in claims review and other safeguards.

Counterbalancing prospective payment's positive incentives to control costs are, depending upon the system's design, incentives to inappropriately increase case loads and increase or decrease the units of service provided. The positive aspects of prospective payments could be largely negated without safeguards to ensure the appropriate use of services.

Finally, the administration has also announced that it will propose in the future a coordinated payment system for post-acute care. ProPAC has also suggested a consolidated or bundled payment system for both acute and post-acute care.

Such payment methods would give providers covered by them incentives to furnish care in the least costly way over an inpatient's entire episode of care. However, these systems also raise a number of questions about how to set payment levels, who receives the payment, and a control is needed to prevent the new incentives of such a system from adversely affectthe ing patient care.

In conclusion, it is clear that the current payment methods for providers of post-acute services for Medicare beneficiaries need to be revised. As more details concerning the administration's or others' proposals for revising these systems become available, we would be happy to work with the committee and others to sort out the potential implications of suggested revisions.

Thank you very much. I'd be happy to answer any questions you or members of the committee have.

The CHAIRMAN. Thank you very much, Dr. Scanlon.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. We will have a number of questions, but we will hear, first, from Dr. Antos.

STATEMENT OF JOSEPH R. ANTOS, PH.D., ASSISTANT DIRECTOR FOR HEALTH AND HUMAN RESOURCES, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. ANTOS. Thank you, Mr. Chairman and members of the committee. I will also confine my comments to the prospective payment proposals for skilled nursing facility care and home health services. My written testimony also discusses other policies that could limit Medicare spending on post-acute care services, including those provided by rehabilitation.

The CHAIRMAN. The full statements will be included as part of the record.

Dr. ANTOS. Thank you.

This year, Medicare will spend $13 billion on SNF services and $19 billion on home health services. That spending has more than quadrupled since 1990. CBO projects that by 2002, spending on SNF and home health services will increase by an additional 50 percent.

Increases in the volume of SNF and home health services have driven that growth in spending, and any policy meant to slow the growth of spending must address volume. Both the number of people being served and the volume of services provided to each user have risen remarkably during the 1990's.

Moving from cost reimbursement to prospective payment could help slow the growth of Medicare spending, but there are clear risks associated with such an approach. Prospective payment encourages providers to increase the number of beneficiaries using services, while minimizing the care provided to those patients.

Providers also have an incentive to seek out low-cost beneficiaries with few post-acute care needs, thereby capturing a full payment amount when few services have been delivered. A poorly designed policy could adversely affect both the quality of patient care and the amount of program savings possible under a new payment system.

I will briefly discuss two critical design issues that deal with these concerns: the scope of services covered by prospective payment, and case-mix adjusters.

First, scope of services. Payment could cover the services of different providers or be confined to a single type of provider; it could also be based on an episode of care or on a narrower per-day or per-visit basis. The more inclusive the set of services covered by prospective payment, the less opportunity providers would have to receive additional payments by shifting necessary services outside the unit of service.

Separate prospective payment systems for SNFs and home health agencies would introduce a new incentive for post-acute care providers to discharge patients to another provider as soon as possible. Shifting patients among post-acute care providers is more likely if, as appears to be the case, the services they offer are close substitutes. Such shifting could increase program costs and reduce the quality of patient care.

If payment was further narrowed to a per-visit or per-day basis, providers could increase revenues by reducing the content of services provided in a visit or a day of care. Fewer services provided in a home health visit, for example, could necessitate more visits, each of which would be paid on a per-visit rate. A per-day approach for SNF services, as proposed by the administration, would address the growth in ancillary costs that we have seen in the past decade but would do nothing to limit growth in the number of days of care.

The second issue in designing a prospective payment system for post-acute care is case-mix adjustment. Case-mix adjusters modify payments to better match the cost of providing necessary treatment. Adequate adjustment can safeguard against both excessive program spending and risks to beneficiaries.

RUGs-III, for example, might be useful for a per-day payment system for SNF services. This is the case-mix adjuster that HCFA has been testing in a demonstration phase. But HCFA has yet to determine either the unit of service or the case-mix system for its home health prospective payment proposal.

To conclude, the current payment structure of fee-for-service Medicare fails to give post-acute care providers an incentive to constrain spending, and past actions that broadened the benefit beyond true post-acute care have greatly contributed to the growth of program spending. Within this context, it is difficult to design policy options to slow the growth of that spending.

We should, however, keep in mind the lessons of past efforts to reduce the spending growth in fee-for-service Medicare. Squeezing down on one part of the problem has often resulted in a shift to spending elsewhere in the Medicare system.

Dealing with post-acute care spending in a piecemeal fashion runs a similar risk. Nonetheless, there is no doubt of the need to address this rapidly growing component of the Medicare program. That concludes my comments. I would also be happy to answer your questions.

[The prepared statement of Dr. Antos appears in the appendix.]

The CHAIRMAN. Well, thank you very much, gentlemen. As you outline in your testimony, the problem we face is serious and there is not a very ready answer as to how to solve it.

Now, there has been a great deal of discussion about prospective payment. In one case the administration has proposed a per diem PPS, others have discussed episodic. Would you comment on both of those proposals and which you think is most effective? I would like to get the reaction of both of you gentlemen. Dr. Scanlon?

Dr. SCANLON. Certainly, Mr. Chairman. In terms of the skilled nursing facility use that we have seen since the change in the guidelines, the primary source of spending increase has been increases in the costs per day. We are now talking about close to $290 a day last year for a day of skilled nursing care.

The cost of the ancillary services has been the primary driving force behind that increase. A per diem prospective payment method, as Dr. Antos indicated, would bring the ancillary costs' growth under control and so would ameliorate some of that problem.

In terms of the number of days of care in an episode, there's been relative stability in that over this period. It's stayed at roughly 35 days per stay. So I think the concern at this point, if we change

the system, we may have new reason for concern. Concern at this point about the days in a stay is not very significant.

The reason I believe the administration moved to the per day rather than the per episode method is because it is difficult to predict for an episode the amount of resources and the length of time that a person is going to stay, and also because there is an incentive created for the facility to "discharge" a patient from Medicare coverage, but in most instances they are not going to be discharged from the nursing home.

Medicare covers the first days of a stay following a post-hospital stay for many beneficiaries, but the beneficiary stays in the nursing home and they would then be paying out of their own pocket, or the Medicaid program would be paying. So in terms of an incentive to reduce the number of days, there can be concern about the implications of that for other payors as well.

The CHAIRMAN. Dr. Antos.

Dr. ANTOS. Let me just add to that. Of course, I agree with Dr. Scanlon's analysis. As a general matter, prospective payment systems, since they pay a fixed rate for a given unit of service, give clear financial incentives to providers to increase the number of units of that service and decrease their costs for providing that service.

So, on those principles, as Dr. Scanlon indicated, a per-episode basis for skilled nursing facility prospective payment encourages early discharge of patients from Medicare payment status to some other payment status.

However, I would focus on the issue of increasing the number of people who receive skilled nursing facility care. Given the strong incentives that exist with the hospital prospective payment to discharge patients early, there could be an increase in the number of patients who could be discharged from the hospital into SNF care.

Although some patients might well need fewer days of care than average, the number of those patients might be substantially more than we have seen in the past.

The CHAIRMAN. Dr. Antos, you mentioned in your testimony that imposing a realistic cost-sharing requirement on home health could also help control costs. Is this a particularly effective way of bringing costs under control? If it is, what would be a realistic amount or what would be the range, would it have a positive effect on fraud?

Dr. ANTOS. Well, there are two considerations that I would address on the question of imposing a co-payment requirement on home health. First of all, would copayments yield program savings? There would be some savings, depending on the design of a policy, if only because some of the costs of those services would be paid for by beneficiaries.

The CHAIRMAN. If that were not paid by Medigap.

Dr. ANTOS. Or other payers, that is right.

The CHAIRMAN. Yes.

Dr. ANTOS. Or Medicaid, for that matter. So there would be some reduction in the costs of home health services to the Medicare program from that route. Second, co-payments probably would not provide much of an additional incentive for lowering the use of serv-

ices, exactly because most people are covered by either private supplemental coverage or Medicaid.

The CHAIRMAN. Let us assume they were not. What would be your comment then?

Dr. ANTOS. Well, if they were not, if there were no supplemental coverage at all for this, then I suspect that there would be some reduction in utilization of services. However, that would depend on the specific policy. For example, a 20 percent co-payment would be a very large expense for a great many people, perhaps unaffordable for many.

The CHAIRMAN. True.

Dr. ANTOS. If there were a modest fixed co-payment—say, $5 a day, with perhaps a limit on the total amount of co-payments over the year that might both be affordable and provide some disincentives for the use of services. It would certainly provide a greater awareness to beneficiaries as to what services they were actually receiving or what services Medicare was being billed for.

The CHAIRMAN. Dr. Scanlon?

Dr. SCANLON. I agree with Dr. Antos, that the potential for this to be a very expensive co-payment for beneficiaries is a concern that you need to consider. As I indicated, about 18 percent of beneficiaries receive more than 100 visits per year, so a 20 percent co-payment would represent a significant burden to them.

There would be some concern in thinking about how you structure a limit, whether you want to have a limit where you just reach a dollar amount of co-pays and then all services after that point are free, or whether you would rather graduate the co-payments so that you maintain some incentive for beneficiaries to consider the value of the services as they receive more services.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. I want to continue where the Chairman left off. That was really going to be my second question rather than my first one, but I think it would be appropriate, before I follow on to what the Chairman brought up about cost sharing.

I held Medicare meetings in 24 of our 99 counties, and I think at every meeting there were representatives of the home health care industry there. Two things they very much, and quite obviously, stated as you would all know, is that they want home health care to be maintained in Part A, and second, they do not like cost share.

So I am asking a question that follows up on it because I think that they know that it is realistic that at least there is going to be a prospective payment system and that the industry itself has even proposed that, probably to circumvent any cost sharing.

My question, following up on the Chairman's, would be this. How would home health care be different from other post-acute care providers where there is already some co-pay? Is there a justification for not having it in home health care and having it in other post-acute services that are given?

Dr. SCANLON. I think in terms of having a service and having the users of that service share in the cost there is no distinction, but the choice as to how much they share and whether they share is your choice in terms of designing this benefit. The difference, though, with home health, I think, is the extent of use.

Most other users of services are going to have a relatively limited amount of service. With home health, we have this significant share of users who use quite a large volume, and therefore a co-pay without some limits could be quite negative for them in terms of trying to meet that co-pay.

Senator GRASSLEY. So your justification then is that more people use it—a broader cross section—and for a longer period of time. That is why you would not have co-pay in home health care as opposed to other post-acute services.

Dr. SCANLON. Well, on why you would structure it differently for home health care, I do not think it comes down to a question of whether you would not have copayments, it comes down to a question of how you might structure it.

Senator GRASSLEY. All right.

Dr. ANTOS. Senator, I think you raise a broader question about the structure of Medicare cost-sharing requirements. This problem of potentially burdensome cost sharing for beneficiaries who need more services is not just a potential problem for home health, it is a real problem for hospital services, for example.

And this suggests that restructuring Medicare cost-sharing requirements along the lines of the kind of health insurance that you and I both have—to limit out-of-pocket spending for beneficiaries for all services on an annual basis, but also to have more reasonable cost-sharing requirements, again for all services—might be a very worthwhile step.

Senator GRASSLEY. Has there been any study that indicates where we have had cost sharing and then extended it to home health care—like from Medicaid or the private insurance market—whether or not it has affected the cost sharing principle, and has it affected quality in any respect?

Dr. SCANLON. I know of no study like that. There has been some look at cost sharing within the area of long-term care services in the home, but it has primarily been focused on the question of the change in utilization that may come when there is cost sharing, and it has found very, very small effects. But those studies were handicapped by the fact that there is not a lot of experience with cost sharing for home care. It is not present in Medicare, it is not present in Medicaid.

With the private insurance arrangements, there are often a number of visits that you receive from your private insurance and then you may have to pay other visits completely out of your own pocket. Tracking those is very difficult, so the studies pose a problem in terms of identifying the effect.

Senator GRASSLEY. Let me quickly move on to my last question, which was going to be my first question. This would be to both of you, but starting out with the Congressional Budget Office, because you did anticipate in the prospective payment system that there would be a gaming of the system, and that about two-thirds of what you normally think you would gain would be lost because of gaming the system. In other words, over-utilization or use that would not be there otherwise.

My question is, what is the basis of that assumption, where did the two-thirds figure come from, and, most importantly, has anything changed in the last 2 years, has the industry's new prospec-

tive payments proposal got anything in it that gives you confidence that we can use a lower offset at this time?

Dr. ANTOS. Well, is the question how much would a change in payment systems induce increases either in the number of beneficiaries receiving services or in the amount of home health services?

Senator GRASSLEY. Yes.

Dr. ANTOS. Obviously, there is a great deal of judgment associated with that. Our analysis was based on consideration of several years of program experience, looking at the potential for very large increases in both forms of utilization in home health in response to prospective payment incentives.

Our analysis also assumes that a separate prospective payment system for home health would open up new opportunities for other post-acute care providers to discharge patients early into the home health setting, and vice versa.

The offset does not just reflect an increase in the use of home health services, but it is generally reflective of an increase in program costs that could occur if we introduced new incentives to increase utilization.

Senator GRASSLEY. Do you have any comment on that from the point of view of the General Accounting Office?

Dr. SCANLON. We feel very strongly that there is a need for better administrative oversight of the home health benefit. As we reported last year, the amount of review of home health claims has declined dramatically. In the late 1980's, about 60 percent of home health claims were reviewed, today it is less than 3 percent of home health claims.

A prospective payment system creates an incentive to identify additional cases and provide services to those additional people. We need better scrutiny to determine that people genuinely qualify for the home health benefit.

In terms of the prospective payment system that was in the Balanced Budget Act and in industry's proposal, both of them put limits on the amount of savings that can be retained by the agency, which does help in terms of reducing some of the incentives to serve beneficiaries that should not be home health patients, but there still is an incentive to do so. So I think that we do need the oversight.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

We have come full circle with home health care. I can remember back to the late 1980's when a lot of us thought that home health care was the way we were going to save money, as compared to hospital stays. It was like doing the Lord's work, both in terms of patients and in terms of cost of health care.

Then you give in your testimony these extraordinary increases in home health use. There have been some of us since the 1980's who have supported PPS demonstration projects in home health care, and you have interesting statistics here. You say that the average number of visits per beneficiary is 27–72 visits per episode. But then you say the average cost of each visit grew modestly, with a shift from skilled towards unskilled visits. That would, I suppose, depend upon a patient's functional ADL limitations.

I guess my question to all three of you would be is there anything wrong with doing PPS on home health care now? You imply that as you ratchet down what you pay, you begin to tread that fine line of maintaining quality of service when you address the number of episodes of care and the cost of this service. But we have faced that in other areas and our system is still called reasonably good. So what would be your views on that?

Dr. SCANLON. I do not think we meant to imply at all that there is a reason not to do prospective payment for home health care. I think what we meant is that there is a reason to do it carefully.

In fact, the current cost limits on home health care have served in some respects as a prospective system on a per visit basis, and we have seen that they have not been effective in controlling the spending on this service, so we need to think about a per episode system for home health care.

Doing that, we also have to be sensitive to the idea that we do not really understand home health care. I think what you were talking about in terms of our hopes in the 1980's, most of them have been realized. People are discharged from hospitals earlier and they are receiving some services at home at a lower cost after that discharge.

Senator ROCKEFELLER. Does that make up for the entire 60 percent increase in the number of providers of home health care?

Dr. SCANLON. No, it does not. It is just that, in addition to those patients for whom money is being saved by having them served at home, we are serving a lot more patients that we did not serve in the past. These are people that need services, but in the past they were not receiving them through Medicare. They are the population or the patients that very frequently are getting primarily aide services over a long period of time, and that is where the volume in terms of number of visits is really driven.

So that is, I think, what has happened to home care. Some of the original intent and some of the original hopes have been realized, but in addition it is starting to serve a new function. Going back to your question, we think that a prospective payment system can be designed now that would be effective in terms of controlling spending, as well as protecting the quality of service and access for beneficiaries.

Senator ROCKEFELLER. But then you really did give warnings about doing it carefully and you just repeated that. You implied that should be left up to us, I thought—or maybe you did, Dr. Antos—as opposed to HCFA.

Dr. SCANLON. We think that you have the information and we are certainly willing to help you in terms of developing the information to make choices in terms of a per-episode payment, in terms of structuring a system like the system that was in the Balanced Budget Act or as the industry has proposed in which there is a sharing of savings which is a protective element. I think those kinds of decisions certainly are something that could be done in the Congress as opposed to delegating it all to HCFA.

Senator ROCKEFELLER. All right. Dr. Antos, let me just use you for the last question, then you can slip in a comment on this one. We now have separate acute and post-acute hospitals. Is that necessary? Could we not get into a continuity of care situation where

you just had the person staying in the same with bundling or blending of payments?

Dr. ANTOS. I would agree with that. There is a great deal of overlap among post-acute care providers. And, as we have seen, there is increasing overlap between acute hospital care and post-acute care.

The justification, I think, back in the 1980's to separately identify and keep in the cost-based reimbursement system certain kinds of hospital units was based on the understanding that certain kinds of hospitals deal with a more difficult type of patient, a longer-term type of patient. However, the system has clearly evolved such that spending in rehabilitation facilities and long-term hospitals has increased greatly.

In addition, increasingly we find the hospital-in-a-hospital phenomenon, where a wing or a floor of a hospital is redesignated as a separate long-term care hospital. That could increase program spending as patients were shifted from the acute care bed to a bed in the same facility that was paid on a different basis.

Senator ROCKEFELLER. Is it incorporated on a different basis?

Dr. ANTOS. They are required to be distinct from the inpatient, PPS hospital. But many of these units exist on the campus of a PPS hospital.

Let me just add quickly, the question of whether HCFA is prepared to implement a home health prospective payment system bears considerable scrutiny. Administrator Vladeck himself has indicated that HCFA is still considering what the unit of service should be, and that is needed to determine the appropriate case-mix adjuster, which would be absolutely essential for prospective payment.

There is also the real danger that separate payment systems would exacerbate the basic problem of premature discharge from a higher level of care.

Senator ROCKEFELLER. Thank you both.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kerrey.

Senator KERREY. Thank you, Mr. Chairman.

Dr. Antos and Dr. Scanlon, your testimonies dealt with what kind of methodology should we use, what kind of change in law should we adopt to help control the cost of these rapidly growing programs.

I want, Dr. Antos, the first set of questions to broaden the consideration a bit. You have the responsibility inside the office to be responsible for more than just Medicare, is that right?

Dr. ANTOS. That is correct.

Senator KERREY. I mean, you analyze all spending programs inside of Health and Human Services.

Dr. ANTOS. That is right.

Senator KERREY. I have met with home health people in Nebraska that are concerned about this, and skilled nursing facility people that are concerned about this. However, the broader problem, it seems to me, as you look at the overall budget, is that we are eroding our capacity to put money into other programs as a consequence of growth in these areas.

I mean, in spite of all the huffing and puffing, the Federal Government has spent, on average, about 20 percent of the GDP over the last 60 years, with a little blip during the Second World War and during the Vietnam War, but other than that about 20 percent. But the mix is changing.

Under the President's balanced budget plan, we are going to shift another 4 percent of Federal spending from discretionary spending over into mandatory spending. Mandatory spending will grow from 66 percent to 70 percent. That is $68 billion in 1997 money that will go from the discretionary accounts, both defense and non-defense, over into mandatory spending. It seems to me that that has got to be the context for our discussion.

Specifically, in Nebraska, for example, that means that we have 200,000 citizens over the age of 65, on whom we spend about $3 billion. The year-to-year spending increase will be $400 million on those 200,000 people. There are 330,000 school children in our public and private school system on whom we spend $1.6 billion, and the incremental spending is going to be $50 million

We have a waiting list today on WIC. We are underfunding Title I. We are underfunding Head Start. Every community group that I talk to at home is concerned about the lack of adult-supervised activity for children as a consequence of what is going on in the economy today, with both mom and dad out there working.

There is an increased demand, in short, to spend more money on children, but an inability to do it as a consequence of this growth in mandatory programs. Yesterday Senator Hatch and Senator Kennedy introduced a proposal that seems attractive to me. It proposes to tax cigarettes—maybe one of the few things where the Laffer curve encourages us. If consumption decreases as a result of a tax increase, that seems to be a favorable outcome.

In order to provide the States over 5 years, as I understand it, about $20 billion to try to insure 5 million of the 10 million uninsured children in this country. I mean, are you troubled as you look at this budget, even under the President's balanced budget plan?

I would like to eventually get to the questions of about whether or not the proposals will control the growth, as you are saying that they will. But, even if they do, are you troubled by the additional shift of 4 percent from discretionary spending over into mandatory spending, given what is going on in the country and the problems that our children face?

Dr. ANTOS. Senator, you raise very serious questions of great concern. In the context of Medicare, the issue is not just a post-acute care issue; clearly, it is an issue of the total growth of Medicare spending, not just the growth of one component.

As you suggested, anything that is done in Medicare could have a Federal budgetary impact on the Medicaid program and a similar impact on State budgets for Medicaid, and the chain of fiscal relationships continues down the line.

So what we consider doing in the Medicare program greatly affects our ability and flexibility to devote resources to other types of programs. Again, that suggests to me that looking at a broader perspective is necessary when dealing with Medicare.

Senator KERREY. Even under this proposal, Dr. Antos, and that seems to be the central question as to whether or not you are say-

ing the growth of skilled nursing facilities and home health agencies went from, in the first case, $2.8 billion to $9.1 billion, you are showing a $12.8 billion baseline in 1997 for skilled nursing facilities.

Under your proposals, you are saying that it will go to $19.2 billion, which is a substantial decrease in the annual rate of growth, from 26 percent down to about, what is it, 8 percent, or 8.4, somewhere in that range.

Likewise, on home health agencies you are going from $19 billion in 1997 to $29 billion, which is almost a quartering, about a 25 percent rate of growth, 25 percent of what we have experienced over the last 5 years.

Even with that, you are talking about a $17 billion increase in spending, even with that. I mean, do we not need to alert Americans that these 2-year-old children out there on whom we are currently under-investing are going to be 22 years of age 20 years from now, and those are the people that we are going to count on to support the 77 million baby boomers who will be retired then?

Do we not need to alert Americans to a general problem that we have got of growing inequities and investments occurring between our children and our parents? I mean, is there not a problem here where we are narrowing down on something I think is quite important, which is, how do we control the growth of a rapidly growing program. Even with the controlled growth, we are going to spend a substantial increase in these two accounts.

If you look at the accounts under your supervision that goes to children, you are not going to see similar growth. In fact, in some accounts you are going to see real declines. I mean, should we not be alerting the country to a bigger problem that is occurring inside of our budget?

Dr. ANTOS. Yes. I think that, in fact, Congress has been trying to get the word out. The trustees of the Medicare program and the trustees of the Social Security system have also issued similar warnings.

Senator KERREY. Well, then why does the President not support the Boskin Commission's recommendation with a change from the CPI to a cost of living increase that is accurate? I mean, that alone is $1 trillion over 12 years, supported by economic analysis. Well, it is a policy option.

Dr. ANTOS. I really cannot comment on that particular question.

Senator KERREY. This is it is not defensible. This is not defensible in light of what we are doing with our current spending, particularly where we are going to be 7 years from now. I just do not think it is defensible.

I mean, I do not think any kind of the examination of the problems that this country faces, particularly the problems facing young Americans and the difficulty that they are having in early childhood. I do not think any analysis can conclude that our current spending mix is addressing those problems, let alone where we are heading if we continue on the current baseline.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator D'Amato.

Senator D'AMATO. Thank you very much, Mr. Chairman. I think Senator Kerrey should be commended for his candor, because we

just have too much in the way of shell games, whether it is $68 or $86 billion and you just shift it from one area to the other, and you say, well, now Medicare is safe. Then you take the money from general funds. As the Senator has pointed out, those are the discretionary programs. Where are we going to get money?

We all signed on to a resolution to say that we want an increase, and I would like to know what Senator would be opposed to the proposition of doubling the money for National Institutes of Health and all of the work in cancer research, AIDS research, you name it, that people come to us to support. I think Senator Mack has put out a resolution, and I think it passed unanimously 98–0, sense of the Senate, doubling the amount of money that would be spent. But where do we get it? I mean, we just willy-nilly in this budget took $86 billion and said, oh, no, it is not going to be Part A Medicare, it is going to be Part B. And, by the way, we are not even going to ask for any rate increase, which is really extraordinary. Extraordinary.

Why do we not eliminate the premiums altogether? Why should we have people pay anything? It is a fiction now. The average payment is about $45 a month, and I think the cost is $145, in round numbers. You have millionaires whom we are subsidizing. We actually subsidize wealthy, wealthy Americans, by any standard, who are retired.

So you have got some poor guy out there who is working, he is working in a restaurant, he has got three kids, he is making $30,000 a year, and he is helping to buy insurance for wealthy Americans. We do not even have the courage to say, let us have some means testing. This is preposterous.

I have to tell you, I do not direct these comments to those panelists who are here and those people who are working and attempting to come up with cost-effective ways of containing growth in spending in these areas and getting maximum efficiency, and getting efficiency and keeping good medical care and assuring it. It is easier said than done. It is weighty and it is difficult, and I commend you for your efforts.

But I have to say that this kind of shell game is just unconscionable. I have seen it in the past. I do not want to say that this budget is the only one. I remember when we had some guy by the name of Stockman who used to come here, and if he did not cook the books, he cooked the books worse than anyone I ever saw. But this is a new way of cooking the books.

He used to do it by just anticipating greater growth than you could ever possibly reduce the interest rates that we would have to spend, a point here, a point there, and before you know it, to paraphrase Everett McKinley Dirksen, you are talking about billions and billions of dollars. That is the way he used to cook them. Well, this proposition is the same. It is absolutely scandalous. It is shocking. It is wrong. It does nothing for cost containment. It does nothing to fix responsibility.

And, by the way, let me ask you one question. Have you ever measured where there are co-payments that people have to make as it relates to some service that they get, some co-payment; what the effect is when some co-payment is called for? Is there a reduc-

tion in the rate of increase where you see co-payments being introduced in the programs?

Dr. ANTOS. Well, as a matter of human nature, Senator, anything that is free is used to the fullest extent that the person might feel is appropriate.

Senator D'AMATO. So what is so difficult about having a modest, modest co-payment plan that will create a situation, not one that is going to bankrupt people, but where they will then be concerned as it relates to the bills that the Federal Government is picking up and that the States are picking up in these various programs. They will say, wait a minute, you should not be charging this and I do not want to pay that extra, whatever.

It just seems to me, if we are going to get into this area of trying to get the most effective and efficient medical care possible at the greatest efficiency, that those are the kinds of things we have to be looking at. But I have to tell you, I am not encouraged by what I see. I think it is a shell game.

I think it is wrong. I am particularly disturbed by this willy-nilly transfer of $86 billion in home health care costs for Medicare Part A to B, and then saying, oh, this will not increase Part B, because what we are going to do is, the general Treasury is going to pick it up. Now, that is just scandalous and shocking.

The people in the media, they do not say a thing about it. It is not sensational. They just go along with it. So where is their responsibility in terms of saying, come on, this is not right, particularly those people who cover this. It may not make headlines, but where are we going to get that $86 billion, what programs are we going to cut? That is what Senator Kerrey was alluding to. Do not fund young people. We have uninsured Americans today. We are looking to find out how to do that.

We just reduced $86 billion of revenue because we just assigned it and we said, oh, we saved Medicare. Guess what? We did not increase costs. No one pays more, et cetera. So we are just pandering. It is just a pandering, absolute, total. It is unconscionable.

I want to say that Senator Kerrey is absolutely correct when he says that there are vast segments who would be hurt—and he did not say this, but who are being hurt today—by not having sufficient resources to them. I think this kind of shift just adds to that burden.

I thank the Chair, and I commend my colleague.

The CHAIRMAN. Let me ask one final question, if I may. It is projected that these programs are going to grow roughly 9 percent a year. If we put in an effective PPS, how much do you think that can be reasonably expected to lower the rate of growth? I would like to ask the same question in respect to cost sharing. If we had an effective cost sharing program, to what extent do you think that would reduce the cost of the rate of growth? Who wants to start? Dr. Antos.

Dr. ANTOS. Well, Senator, the answer to these questions depends——

The CHAIRMAN. Crystal ball, I know.

Dr. ANTOS [continuing]. Completely on the specification of the proposal. With respect to prospective payment, the only suggestion I can give is that the President's proposal for skilled nursing facil-

ity prospective payment and a few other policies for skilled nursing facilities would save, according to our estimates, $7.6 billion over the next 5 years. That is a substantial amount of money.

The CHAIRMAN. What percent would that be?

Dr. ANTOS. Let me see. Well, in 2002, for example, we are projecting that $2.4 billion in savings would accrue from those policies, which would bring outlays down from $19.2 billion to about $16.8 billion, so that looks to be about a 12.5-percent reduction in that year.

As far as what that does to the rate of growth, it shaves it somewhat. I cannot do the calculation in my head, but it does bring it down.

The CHAIRMAN. Dr. Scanlon?

Dr. SCANLON. Since CBO has the crystal ball that gives you the quantitative estimates, I would respond from a qualitative perspective. I think the prospective payment system for both home health and skilled nursing facility care has the potential of dealing with the problems that have been driving the growth in those services.

In the case of home health, the number of visits in an episode-based payment would provide an incentive to control the number of visits. In the case of skilled nursing facilities, the growth in ancillary services and a prospective payment system, even on a per-day basis, would give you some controls over that.

In terms of the cost sharing and its impact, I think the concern of people is that there is so much secondary coverage, Medigap and Medicaid, that the effects of cost sharing in terms of influencing the volume of services that are going to be used is going to be very significantly muted by that secondary payment that is available.

The CHAIRMAN. Well, gentlemen, thank you very much for your testimony today. Undoubtedly, as we proceed with the process, we will seek your expertise and advice.

We will now hear from a panel of post-acute care providers. We will, first, hear from Ms. Margaret Cushman, who is president, VNA Health Care, Inc., of Hartford-Waterbury, Connecticut. She will testify on behalf of the National Association for Home Care.

We will then hear from Mr. Michael Walker, chairman and CEO, Genesis Health Ventures, Inc., Kennett Square, Pennsylvania, on behalf of the American Health Care Association.

Finally, we will hear from Mr. Tom Scully, who is president and CEO of the Federation of American Health Systems here in Washington.

The committee will hear the testimony from the panel, then we will turn to questions.

Ms. Cushman, would you please begin.

STATEMENT OF MARGARET J. CUSHMAN, PRESIDENT, VNA HEALTH CARE, INC., OF HARTFORD-WATERBURY, CONNECTICUT, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. Thank you, Mr. Chairman. My name is Margaret Cushman and I am president of VNA Health Care, serving Greater Hartford-Waterbury, Connecticut. I also currently chair the Government Affairs Committee for the National Association for Home Care, and serve on its Prospective Payment Task Force.

Incidentally, I have been in executive home care for over 20 years now and have lived through many of the periods that were described by the former panel.

Congress has before it right now a very unique opportunity to improve the Medicare home care benefit in a way that home care supports and will stand behind. The home care industry's revised Unified Prospective Payment Plan introduced last year by Representative Nancy Johnson incorporates the best elements of the Balanced Budget Act and the administration's proposal last year.

Our goal was to craft a prospective payment plan that would accommodate deficit reduction requirements and address HCFA's concerns about implementation. Let me be direct regarding the context in which we offer this proposal.

In 1995 when the industry found co-payments and bundling unacceptable, Congress challenged us to develop another way to come up with the savings. This prospective payment proposal was developed as that alternative, and it is in that context that we offer it today.

Our concerns and issues, incidentally, surrounding co-payments do appear on page 25 of my written testimony, and I would be happy to answer any questions on those.

Prospective payment is a vast improvement over current cost-based reimbursement. Cost-based reimbursement is complex and costly to administer. It offers, as noted previously, no incentives for provider efficiency, whereas, PPS gives providers incentives to both reduce visit costs and total case costs.

The unified industry plan entails a three-phased approach to achieving episodic prospective payment, starting with an interim prospective plan which would use existing data and processes with a per-visit payment and a per-episode cap on an annual basis, then moving to an episodic prospective payment system with refined case-mix adjustment, and finally would require development within 5 years of a full prospective payment system.

Current Federal law and State practice acts would prevent inappropriate changes in patterns of care and utilization of ancillary staff as opposed to professional staff.

We are deeply concerned, however, that the Congressional Budget Office may again impose a 66 and two-thirds percent offset on the prospective payment plan, which would dramatically reduce its savings. An offset of that magnitude would be almost impossible to overcome.

A few remarks about the President's budget. By design, the prospective payment system for hospitals has led to shorter lengths of stay for home care and for other post-acute providers. The President's budget would deeply penalize home health providers for this growth.

Beyond our concern that home care would be cut disproportionately, we are very concerned that the actual care would be reduced to needy Medicare beneficiaries, especially provisions that would transfer some of the home care coverage from Part A to Part B, restrict eligibility for home care, deny home care based on normative standards, and lump all post-acute services into a single payment.

The transfer from A to B would do little to address the underlying insolvency issues facing the Part B trust fund as previously ad-

dressed in this hearing, but would have the potential to dramatically raise the premiums under Part B for beneficiaries if it were passed through to them.

While NAHC endorses prospective payment as a fundamental improvement in Medicare, the administration's proposal is flawed in a number of ways. It essentially continues the present cost-based reimbursement system with no incentives for providers to reduce cost and increase efficiency.

It proposes the Secretary devise a new plan without any Congressional oversight or participation by the industry or consumers, and it would reduce the home health cost limits and per beneficiary limits by 15 percent prior to implementation, which would be a drastic and unnecessary reduction, and a reduction which might be counterproductive to our future goal of cost-effective episodic care.

The administration would also delay updates in the Medicare cost limits for 3 months, which would reduce limits by approximately $10 per skilled nursing visit, and $5 per visit for home health aide services, and would freeze and maintain the savings from the cost limit from the past 2 years. Those two provisions would add up to a 17 percent reduction in the current payment for home care cost limits.

It would also restrict eligibility for home care by changing the definitions of intermittent, the definitions of homebound, which would remove the accessibility to this benefit for a wide number of beneficiaries, and would further propose new limits on the homebound eligibility requirement for disabled patients and individuals who attend adult day care, many of whom now may receive their health care services through home care.

Another troubling provision would create normative standards and deny care that was outside those normative standards. Prospective payment, on the other hand, would use a proven case-mix adjustor to achieve such normative standards.

NAHC is strongly opposed to the President's proposals to bundle home care payments with other post-acute care providers and to allow States to impose fees on providers and repeal important fraud and abuse provisions. We are pleased that respite benefit has been suggested, although it falls short in many respects.

Mr. Chairman, I would like to thank you again. We look forward to working closely with you and with the committee to bring prospective payment to enactment, and on working with you on these other important issues.

The CHAIRMAN. Thank you, Ms. Cushman.

[The prepared statement of Ms. Cushman appears in the appendix.]

The CHAIRMAN. Mr. Walker, we will turn to you next. You are almost a Delawarean, but not quite.

Mr. WALKER. Only a few miles away.

STATEMENT OF MICHAEL R. WALKER, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, GENESIS HEALTH VENTURES, INC., KENNETT SQUARE, PENNSYLVANIA, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Mr. WALKER. Chairman Roth, I am Michael Walker, chairman and CEO of Genesis Health Ventures. I actually founded the com-

pany in 1985. Today we are a diversified provider of health care services to the elderly, serving more than 75,000 individuals.

We provide these services through our eldercare networks, which are in five regional markets on the East Coast of the United States. Approximately one-third of our customers are residents of nursing facilities that we own and manage in 12 States, including Delaware, Florida, West Virginia, Vermont, and Rhode Island.

I am speaking today on behalf of the American Health Care Association, a federation of 50 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing, and subacute care providers, and the 75,000 individuals that Genesis Eldercare serves daily.

Today's hearing is concerned with how certain policies within the existing Medicare fee-for-service system relate to care received by beneficiaries once they leave an acute care hospital.

One of many questions is why an older person should first have to go into a hospital at all to receive care that they could receive elsewhere. A number of changes in the way that post-hospital services are paid for have been proposed and should be enacted in order to contain costs and foster more appropriate care.

Candidly, these changes must be made, but they must lead us to something more, something fundamentally different, to a time when the Medicare program will no longer purchase in a piecemeal fashion millions of units of service on an annual basis from hundreds of thousands of different providers on behalf of its millions of beneficiaries.

This program that is so vitally important to our older people cannot be preserved, and will not deliver full value to its clients or to its taxpayers until it is changed—changed fundamentally from being a direct purchaser of particular services to becoming a funding source for comprehensive health care solutions chosen by beneficiaries in a competitive marketplace.

True reform of our eldercare system cannot happen if we continue to maintain multiple funding sources aimed at the same client. We all have one funding source, the elderly have as many as five—with no particular program, provider, or level of government being responsible for either the cost of care or the well-being of the client.

However, if the substantial public investment in care of older people is redirected to empower consumers to act in a true competitive market, the results will be dramatic: lower costs, better care.

I urge the committee to move reforms in this direction as you search for solutions to the Medicare crisis. Let me now be specific and address the administration's 1998 budget proposals that affect skilled nursing facilities.

First of all, I am glad to say that the budget provisions concerning skilled nursing facilities, primarily the administration's prospective payment system, was scored by the Congressional Budget Office at $7.7 billion over 5 years, more than $700 million over what the President requested from our industry.

We could support the President's proposed level of $7 billion over 5 years, but feel any more would inhibit our ability to offer quality skilled nursing services and to provide healthy competition in the post-acute sector.

We would also like to point out that the separately proposed salary equivalency guidelines would reduce health care spending by $1.7 billion over 4 years, meaning that our industry is being asked to contribute far more in savings than meets the eye. We urge you to take these factors into account before allocating reimbursement reductions.

We support the administration's case-mix-adjusted per diem prospective payment proposal. We will want to see final language to be sure it includes an outlier policy, and that the case-mix adjustment methodology covers the full range of skilled nursing subacute services being provided in our facilities. Nevertheless, a per diem prospective payment system is the right way to obtain the cost savings needed in Medicare at this time.

It is far preferable to challenge providers to achieve savings by an efficient operation and to reward them for doing so than to simply cut provider payment rates. Implementing a per diem prospective payment system now will enable the pricing of services for entire episodes of care or the refinement of capitated payments in the future.

We cautiously support consolidated billing for all SNF services to Part A patients, and continued internal discussion regarding consolidated billing to Medicare Part B patients.

In addition to those provisions directly affecting SNFs, our written statement also conveys our views on a few other proposals. For example, we oppose the imposition of user fees for initial certifications under Medicare.

What I would like to leave you with, in conclusion, is that the overriding goal on health care reform should be to build a system focused on the person and superior outcomes. That is not the system that we have today. What we have today promotes cost shifting between State and Federal Government, it promotes cost shifting between payor and provider, between hospital and nursing home, between home care and nursing home and hospital. It is not focused on the individual patient.

These systems today, believe it or not, promote the imprisonment of the elderly in institutions rather than keeping them at home. Let us free our parents as we redefine this system. Thank you very much.

The CHAIRMAN. Thank you, Mr. Walker.

[The prepared statement of Mr. Walker appears in the appendix.]

The CHAIRMAN. Mr. Scully.

STATEMENT OF THOMAS A. SCULLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, FEDERATION OF AMERICAN HEALTH SYSTEMS, WASHINGTON, DC

Mr. SCULLY. Mr. Chairman, Senator Rockefeller, thank you for having us here today. My name is Tom Scully. I am president and CEO of the Federation of American Health Systems, which is 1,700 investor-owned and managed hospitals and health systems around the country.

Most of our members—about 1,100—are acute care hospitals, Tenet, Columbia HCA, Universal Health Systems, which you may have noted about George Washington Hospital in Washington the other day. They are our largest members. But we also represent

the bulk of the PPS-exempt specialty hospitals, and that is what I am here to talk about primarily today.

I think we are uniquely qualified to hopefully help the committee in looking at specialty hospitals in this area. If you look at the rehabilitation sector between HEALTHSOUTH, which is the biggest rehabilitation chain in the country and Horizon/CMS, we represent about 70 percent of the freestanding rehabilitation hospitals in the country.

In the psychiatric area, with Magellan Health Services, which has about 100 hospitals, and various other federation members, we represent over 50 percent of the freestanding psychiatric hospitals in the country.

In the area of long-term care hospitals, with Vencor, American Transitional Hospital, and again Horizon/CMS, we represent about 35 percent of the freestanding long-term care hospitals in the country.

So, while we tend to focus you frequently on acute care hospitals, we do have a very strong and active interest in the area of specialty hospitals. This year, I think the area of specialty hospitals, policy-wise, is a particularly intense year in policy changes.

Specialty hospitals tend to be looked at as kind of the stepchild of hospital policy in Medicare, but there is $13.3 billion being spent in that area this year. The acute care policies are big, the money is big, the changes are big, but they tend to be rehashes of issues that we have been talking about for five, six, seven years.

In the specialty hospital area this year, there are very, very big policies. They have a very intense impact on all the specialty hospitals, as well as many acute care hospitals.

We are more than willing to share our portion of the appropriate baseline reductions, cuts, whatever you choose to use as the label, this year. But we would like to be, and we have been with your staff and committee so far, actively involved in trying to help you make those decisions.

Generally, the President's budget, in the acute care area, we have been fairly supportive of and like many of the policies. In the post-acute PPS-exempt area, I would say that we have been very unhappy with it and think a lot of the policies are misguided and are heading in the wrong direction.

The first thing to understand, I think, about PPS-exempt hospitals is they are very sensitive to Medicare cost cuts. The average acute care facility has about 40–45 percent of its patient revenues coming from Medicare. The average PPS-exempt specialty hospital gets 60–75 percent of its patient revenues from Medicare. So when you make changes in Medicare in that area you have a much bigger impact on the facility.

For instance, for the next year, even though they represent just under 6 percent of all Medicare hospital revenues, over 13 percent in 1998 of the President's budget would come out of PPS-exempt hospitals.

Just to go to specifics for a minute about some of the things that we have the biggest concerns about, I would say across the spectrum of specialty hospitals our biggest concern is the proposal the President has in his budget to rebase TEFRA PPS-exempt hospitals. We think it is a big mistake.

I think ProPAC, your own advisory board, has said that there is no doubt that rebasing PPS-exempt hospitals penalizes efficient facilities and transfers money away from efficient facilities to inefficient facilities. I think a lot of our facilities that are newer that have done well have actually cut costs for Medicare.

I have put a chart up here from HEALTHSOUTH, which, again, as I said, has almost 70 percent of the freestanding rehabilitation hospitals in the country. Their actual average cost per patient day and cost per discharge has dropped pretty significantly in the last 3 years, and that is Medicare cost report data. So our costs are going down. There are, in fact, a lot of old hospitals with low bases and bases that are changing that may need to be adjusted.

HCFA already has a process to allow for an exceptions process that can allow a hospital that is not meeting its cost targets to effectively change them and update them, but an overall rebasing is going to penalize and ratchet down the reimbursement to the efficient people that have been responding to what you have tried to put in place in the last 10 years in PPS-exempt policy, and it is going to hurt the efficient providers and help the inefficient providers. I think that goes exactly in the wrong direction.

Let me say, first, by the way, that I think overall the federation's policy long has been that, really in all these things, acute care policy and post-acute, you are really kind of playing around the edges. We are strongly in favor of the ultimate PPS, which is capitating the whole Medicare system and privatizing it, and we have been for years.

We think there is an awful lot of merit to what you are trying to do in all your different acute care policies, but fundamentally, until you get to a Federal Employee Health Benefits type model where you are essentially buying private coverage for seniors and getting that option, you are always going to be pushing air around the balloon from different provider settings, whether it is acute care to post-acute, or SNFs to home health. You are essentially just moving money around inefficiently in the same process.

So, while we are happy to work with you on all of these things, we would strongly encourage you to, as quickly as possible, do overall reform.

Switching back to the specifics of incentive payments, we are not unwilling to find ways for you to get to your $3–5 billion, depending on the number in your PPS-exempt target for cuts.

The ProPAC recommended, for instance, a minus 2.8 percent on the market basket for acute care facilities. They recommended 0.8 percent for PPS-exempt facilities. Obviously they were concerned about reductions to PPS, so they wanted to give them the bigger update.

We are very willing to take larger cuts in the PPS-exempt update in exchange for not doing what we consider to be shortsighted and not well-thought-out policies, like TEFRA rebasing.

We are willing to have you ratchet down—we are not happy about it—and take a smaller update in the inflation factors in exchange for avoiding those kinds of policies. We are very strongly in favor of moving to a PPS for rehab, for long-term care, as quickly as possible. HCFA has been looking at a Rand proposal that we think is ill-founded.

Just to give you one example why, as I said, and I will wrap up quickly, HEALTHSOUTH in itself represents 70 percent of the rehabilitation facilities in the country, yet the PPS proposal that HCFA has been looking at looked at only two of their hospitals and they hardly used those two.

So the PPS system that HCFA has been looking at, we think, is totally on the wrong basis and we support PPS quickly for rehabilitation and for long-term care. We think the one HCFA is looking at now is inappropriate.

Finally, I will just add, on psychiatric hospitals, I think HCFA and virtually everybody else agrees that, while PPS is a great idea for specialty hospitals, psychiatric facilities really are not ready for them.

There is really no way to measure the problem when someone goes in a psychiatric hospital. There is no way to look at them like you do somebody in rehabilitation or long-term care and decide what the case per payment would be, because the psychiatric system is too complex.

I believe HCFA would agree that there really is no way to move the PPS for psychiatric hospitals. So regardless of what you do to try to reform the PPS-exempt payments for specialty hospitals, I think you are more likely than not going to find you have to stick with it for at least some time to come in the psychiatric area.

So with that, Mr. Chairman, I do not know if it counts, but I did go to Archmere in Claymont, Delaware. I do not know if that makes me a constituent. But thank you for having me today.

The CHAIRMAN. Mr. Scully, thank you for your testimony.

[The prepared statement of Mr. Scully appears in the appendix.]

The CHAIRMAN. I would say to the panel that I think all of us agree that there has to be major reform. Senator Moynihan and I have proposed a special commission to try to bring about what I think you are talking about.

I would like to ask one question. What is the reaction of the panel to the forms as they were provided for in the Balanced Budget Act of 1995?

Mr. SCULLY. Mr. Chairman, I would say the federation strongly supported those. We probably did not like the number overall that went with it of $270 billion, but we had told the leadership then. There are some things we would like some changes on in the PSO language.

But, generically, if you took your 1995 bill that passed Congress and put in a number closer to where the President and Congress seem to be this year in the $100–115 billion range, I think you would have almost universal support from my members. I believe the controversy 2 years ago was over the number, not the policy.

I think if you went with the AHA, the AMA, all the major health care groups, you would find maybe some small disagreements, but the vast bulk of us thought the policy in the 1995 bill was excellent, and we would strongly support you doing the same bill again with a slightly lower number.

The CHAIRMAN. Mr. Walker?

Mr. WALKER. The $9 billion number last year was negotiated hard. There are certainly some differences of opinions, but the in-

dustry was supportive, and we are supportive of this $7 billion number this year.

The CHAIRMAN. Did you see the overall proposal bringing about the kind of reform you discussed in your testimony?

Mr. WALKER. Yes, we have viewed the 1995 proposal as moving in that direction.

The CHAIRMAN. Ms. Cushman?

Ms. CUSHMAN. I think I testified earlier that there was a prospective payment system in the Balanced Budget Act. There were some provisions within that that were troubling, as there were some provisions in the administration's that were troubling. What we attempted to do as a unified industry proposal is to take the best elements of both and combine them into one workable plan that could be implemented now.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I was just asking Dr. Koplowitz, if it was not the case that most of the people involved with health care who are coming in to see us in our office or who are testifying at hearings such as this, are asking for the same or more money in Medicare, where they are involved with that program. I realize that is partly what you have to do because of who you represent and the conditions of your employment. But there are some tricky parts to this also, and I might start with you, Ms. Cushman. You talk about the advantages of PPS and you set up a climate in your testimony of saying: we are for this, we think this is good. I think you are for it because you think it is going to happen anyway. There is something at the end of your testimony which is interesting.

You said, "PPS, by providing desirable market life incentives that encourage the efficient and effective provision of care," and "of the revised unified PPS plan that we are testifying in support of today is a modification of the original."

Then, lo and behold, on page 14, five pages later, you say, "The administration's PPS proposal included in the fiscal year 1998 budget submission falls short of the industry's expectations in a number of ways." Could you be helpful to me on whether you favor PPS or, in fact, have you undercut what you basically said by your obscure statement that I gave last?

Ms. CUSHMAN. I hope that I have not undercut my position. In terms of the position that I represent, it is not only the National Association for Home Care and as the unified industry representative. I have been involved in trying to fashion prospective payment proposals since 1985.

Senator ROCKEFELLER. Could you answer my question, please.

Ms. CUSHMAN. Yes. The administration's proposal moves from a current cost limit cutting mechanism, which is not prospective payment, and would set a beneficiary cap based upon current agency expenditures, while slashing the visit costs, waiting for 1999 or later for the implementation of full episodic prospective payment system.

That would be a delay of an incredible period of time, and we feel that that is a fundamental flaw in not introducing prospective payment now. At the same time, essentially the cost of home care, the cost per visit——

Senator ROCKEFELLER. When would you introduce it?

Ms. CUSHMAN. We would introduce it immediately, within 6 months after enactment. We believe it can be based upon given data if we use the annual current cost of patients as the episodic limit until a better case-mix adjustor can be created.

The problem with the cutting cost limit notion is, it is a generally well-accepted principle that the fewer visits per patient, the higher the visit cost will be per agency. So if you just slash the unit cost, the visit cost, you will be squeezing those agencies who are probably providing the most overall cost-effective care under an episodic system.

If you wait until 1999 to introduce any kind of prospective payment, and at the same time, the beneficiary limit that the President's budget would propose, would allow that agencies have their limit set based upon their normative values. So the high——

Senator ROCKEFELLER. Can I go on to my next question.

Ms. CUSHMAN. Yes.

Senator ROCKEFELLER. I stand by my original hypothesis, but you are skillful and you are good.

To Mr. Scully, in terms of post-acute care hospitals, I guess I would indicate they have strong incentives to have very high costs in the base year of these institutions, which determines payments by TEFRA.

By your chart, you could make a case that if you increase your costs in your first base year, that automatically allows you to show savings thereafter. In other words, cost efficiencies are not really cost efficiencies, they are just the next step to not having to spend as much in the second or third year.

Are the high costs frequently present in these base years due to these financial incentives instead of the complexity of the patient? The second question is, if the cases are not loaded in the base year, what is the problem with changing the base year anyway?

Mr. SCULLY. Can I get her to answer this for me?

Senator ROCKEFELLER. Sure.

Mr. SCULLY. There is no doubt that my argument essentially would be, as I have made to you for years, that I think the whole system is full of perverse incentives. I mean, there is no doubt there is an incentive to employ the base year.

I think if you look at a system like HEALTHSOUTH that has 70 hospitals, many of which they did not build and did not have in the base year, it is hard to find that incentive. There is no doubt that the system encourages you to have an incentive in the base year, but many of these hospitals are 10, 15, 20 years old and they have had inflationary increases in their base payment rate, usually of market basket minus 2 or 3.

So I think when you go out and look at them it would be hard to see that our base payments, especially at HEALTHSOUTH, is above the national mean. I do not believe they are. Is there incentive for any specialty hospital under the current plan to come in and try to have a high base year? Yes.

But I also think the existing incentive payments, to say if you are below it we will split the savings with you, have started to drive costs down. It is very similar to the incentive in PPS, when you give somebody a DRG, if they are below the cost of the DRG

they get 100 percent of the savings. In the PPS system, they get half.

I cannot tell you there are not perverse incentives. We are anxious to go to PPS as quickly as we can get a sound one designed. We would be anxious to turn the whole system, as I said, into one big capitated payment.

So I am not arguing this is perfect, but I think to go out and rebase, which would have massive inequities among all the different hospitals depending on when they were built, while you are trying to get a PPS, just in the short term, does not make sense. I think there are other more rational ways to save the money, and we are happy to find ways for you to save the money.

But to do this for two or 3 years in the interim while you go to PPS, we do not believe makes sense and does, in fact, if you look at the hospitals who are driving down their costs, penalizes them and helps the ones that have high costs, which seems to me to be going totally against where you want to be.

Now, there is no doubt that under the existing system anybody that is smart, if you create crazy incentives, smart people will do them. You have an incentive, when you open your hospital the first couple of years, to try to build up the base. But my view is, that is stupid Federal policy, and people react to that.

Senator ROCKEFELLER. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you very much for being here today. I appreciate the helpful testimony. Undoubtedly, we may want to consult with you further as we proceed with the process. Thank you very much. The committee is in recess.

[Whereupon, at 11:35 a.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Prepared Statement of Joseph R. Antos

Mr. Chairman and Members of the Committee, I appreciate the opportunity to discuss with you the growth in Medicare spending on post-acute care services and options for slowing that growth. Over the past decade, spending on post-acute care services has grown more rapidly than other major components of Medicare spending. That trend is likely to continue unless legislation is adopted to alter the way in which those services are paid for under Medicare, or the extent to which those services are covered by Medicare.

In my remarks today, I will summarize recent trends in Medicare spending on post-acute care as well as projections by the Congressional Budget Office (CBO) for the next decade. I will also discuss some issues that might be considered when designing policies to contain post-acute care spending, and briefly comment on the Administration's proposals.

My discussion focuses on policies that might, in the near term, constrain spending on services from providers in fee-for-service Medicare. Broader strategies to reduce the total cost of the program over the longer term-such as expanding the types of health plans that can participate in Medicare, changing the payment formula to allow the program to benefit from managed care efficiencies, or restructuring Medicare as a defined contribution program-are not addressed. The financing problems facing Medicare over the long term are dramatic, however, and options that focus on adjustments to fee-for-service spending would be insufficient to maintain the life of the program. CBO's recent report, *Long-Term Budgetary Pressures and Policy Options,* analyzes the broader issues of Medicare restructuring for the long term.

GROWTH IN MEDICARE SPENDING ON POST-ACUTE CARE SERVICES

The Hospital Insurance (HI) program finances most post-acute care services under Medicare. Those services are provided by skilled nursing facilities (SNFs), home health agencies, and specialty hospitals including rehabilitation and long-term hospital facilities. The Supplementary Medical Insurance (SMI) program also finances some post-acute care services, including rehabilitation, pharmacy, and medical supplies. My testimony today will focus primarily on SNF and home health services paid for under the HI program.

Medicare covers SNF services only if the patient had a minimum three-day stay in an acute care hospital before being admitted to the SNF. Coverage of home health care, in contrast, does not require a previous hospital stay, and a substantial proportion of home health visits are provided to patients with chronic conditions. Rehabilitation facilities (both hospitals and separate units) and long-term hospitals also provide post-acute care services, although patients may be admitted directly to those facilities. The data presented here reflect total spending by each of those providers for both post-acute care and chronic care.

Recent Trends in Spending

In 1995, Medicare spent $29.4 billion on services from post-acute care providers paid on a fee-for-service basis under the HI program (see Table 1). Between 1990 and 1995, HI spending on those services escalated at an average rate of 28.8 percent a year compared with a rate of 10.5 percent for all Medicare benefits and 6 percent for acute inpatient hospital services paid for under the prospective payment system (PPS). Services provided by SNFs and home health agencies accounted for more than 80 percent of spending under HI on services from post-acute care providers in 1995.

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Although the magnitude of spending on post-acute care services under the SMI program is not known with great precision, it appears to be sizable and growing. In calendar year 1990, for example, intermediaries under SMI paid about $500 million for rehabilitation services. By 1995, that spending had tripled to $1.7 billion.

TABLE 1.—OUTLAYS FOR SERVICES FROM POST-ACUTE CARE PROVIDERS UNDER MEDICARE'S HOSPITAL INSURANCE PROGRAM, FISCAL YEARS 1990 AND 1995

(In billions of dollars)

	1990	1995	Average Annual Rate of Growth (in percent)
Skilled Nursing Facility	2.8	9.1	26.6
Home Health Agency	3.3	14.9	35.2
Post-Acute Care Hospital [1]	2.2	5.4	19.7
Total	8.3	29.4	28.8
Memorandum:			
PPS Hospitals	51.6	69.2	6.0
All Medicare Benefits	107.2	176.9	10.5

SOURCE: Congressional Budget Office.

NOTE: PPS = prospective payment system.

[1] Includes rehabilitation units, rehabilitation hospitals, and long-term hospitals.

Sources of Spending Growth

Three factors have fueled the rapid growth in spending for post-acute care services. First, a host of legislative actions, court decisions, and regulatory changes during the 1980s significantly expanded Medicare's coverage of post-acute care benefits. Actions were also taken to allow more post-acute care providers, including proprietary home health agencies, to participate in Medicare, and more nursing facilities sought certification under the Medicare program.

Second, establishing the prospective payment system for inpatient hospital services in 1983 transformed both the hospital and the post-acute care industries. Under that system, hospitals are given fixed payments based on the medical diagnosis of their patients rather than on the hospitals' cost of providing services. That shift from cost-based reimbursement gave hospitals an incentive to reduce their costs by discharging patients more quickly into post-acute care services. Retaining a separate payment system for post-acute care services gave providers incentives to increase the use of those services and encouraged hospitals to establish their own post-acute care units.

Third, advances in medical technology expanded the types of services that can be provided in less intensive settings. Technical services such as infusion therapies, which until recently would have been delivered on an inpatient basis only, are now delivered in SNFs and in the home. Such advances may prevent the need for hospitalization but, in many cases, they lead to a substantial increase in the use of covered services in post-acute settings. New drug therapies, for example, may require only a minimum amount of monitoring by a skilled nurse-perhaps a blood test once a month-which can be done in a patient's home. That monitoring, however, could count as a skilled nursing service under Medicare, enabling a beneficiary to have access to an array of other home health services including personal care (such as assistance with dressing or bathing) provided by aides. (The Administration has recently proposed to eliminate the automatic eligibility for broader home health benefits that is currently available to patients whose only medical need is to have blood drawn periodically.)

Those factors also encouraged more providers to enter the post-acute care market. Between 1990 and 1995, for example, the number of SNFs ballooned by 40 percent and the number of home health agencies grew by an extraordinary 60 percent (see Table 2). In particular, many hospitals established their own post-acute care units. In 1996, three-quarters of all short-term acute care hospitals had at least one post-acute care unit, such as an SNF, rehabilitation unit, or home health agency. The number of freestanding proprietary home health agencies soared as well.

TABLE 2.—NUMBER OF PROVIDERS OF POST-ACUTE CARE SERVICES AND PROSPECTIVE PAYMENT HOSPITALS IN MEDICARE, 1990 AND 1995

Provider	1990	1995	Average Annual Rate of Growth (In percent)
Skilled Nursing Facility[1]	10,572	14,811	7.0
Home Health Agency	5,718	9,147	9.9
Inpatient Rehabilitation Facility	816	1,024	4.6
Long-Term Hospital	87	178	15.4
PPS Hospital	5,527	5,250	−1.0

SOURCE: Congressional Budget Office.

NOTES: Counts are as of December of each year.
PPS = prospective payment system.

[1] Counts include swing-bed units in hospitals.

Outlays for both home health and SNF services grew rapidly in recent years. In addition, the number of enrollees receiving care nearly doubled between 1990 and 1995 for both home health and SNF services (see Table 3). However, distinct differences in the patterns of service use between those types of providers are apparent.

Aside from the growth in the number of people using services, most of the increased spending for home health is the result of a sharp rise in the number of visits per user. The average patient received twice as many home health visits in 1995 than in 1990. The average cost of a visit, however, grew modestly, reflecting a shift away from skilled nursing visits toward aide visits. Home health under Medicare is increasingly used to compensate for a patient's functional limitations rather than to provide skilled nursing or therapy services.

In contrast, an expanding use of ancillary services, particularly therapy services, and a rise in the number of patients have driven the growth of SNF spending. Unlike routine operating costs, which are paid on a reasonable-cost basis subject to limits, ancillary costs are not subject to limits. Consequently, although the number of SNF days per patient remained fairly constant, total outlays tripled between 1990 and 1995.

TABLE 3.—GROWTH IN THE USE OF MEDICARE HOME HEALTH AND SKILLED NURSING FACILITY SERVICES, FISCAL YEARS 1990 AND 1995

	1990	1995	Average Annual Rate of Growth (In percent)
Home Health Services:			
Users (Millions of people)	1.9	3.4	12.7
Visits (Millions of visits)	62.8	236.4	30.4
Outlays (Billions of dollars)	3.3	14.9	35.2
Skilled Nursing Facility Services:			
Users (Millions of people)	0.6	1.2	14.0
Days (Millions of days)	22.9	40.3	12.0
Outlays (Billions of dollars)	2.8	9.1	26.6

SOURCE: Congressional Budget Office.

Projected Trends in Spending

Under current law, spending for post-acute care services is likely to continue its rapid growth, although not at the startling rates of the past decade. CBO projects that spending for SNF and home health services under fee-for-service Medicare will grow by 9.1 percent a year between 1997 and 2002 (see Table 4). That estimate does not, however, fully reflect the rapid growth of those services. CBO projects that the number of people enrolled in fee-for-service Medicare will decline as enrollment in health maintenance organizations increases substantially over the next decade. Consequently, outlays for SNF and home health services per person enrolled in fee-for-service Medicare will grow by 10.8 percent a year between 1997 and 2002.

POLICY OPTIONS

The rapid growth of Medicare spending on post-acute care services is adding to both the general financing problem facing Medicare and the imbalance of payments

and revenues in the HI trust fund that will soon lead to that fund's depletion. Trimming limits under the current cost-based reimbursement system or developing a prospective payment alternative to the current reimbursement system could slow that growth. Other options include tightening Medicare's coverage standards and imposing greater cost-sharing requirements on beneficiaries.

TABLE 4.—PROJECTED OUTLAYS FOR SERVICES FROM POST-ACUTE CARE PROVIDERS UNDER MEDICARE'S HOSPITAL INSURANCE PROGRAM, FISCAL YEARS 1997 AND 2002

(In billions of dollars)

	1997	2002	Average Annual Rate of Growth (In percent)
Skilled Nursing Facility	12.8	19.2	8.4
Home Health Agency	19.0	29.9	9.5
Total	31.8	49.1	9.1
Memorandum:			
All Medicare Benefits	207.9	312.4	8.5

SOURCE: Congressional Budget Office.

Developing specific policy options to address those spiraling costs is complicated by the overlaps in functions and services that exist among different types of providers. Financial incentives and changes in the delivery of services have blurred the distinctions between the levels of care furnished by acute care hospitals, post-acute care providers, and long-term care facilities. Not only do post-acute care services substitute for some inpatient treatment, but different post-acute care providers can tender many of the same services. Those factors argue for payment policies that provide comparable incentives across different sites of care.

A similar blurring of the distinction between post-acute care and long-term care has taken place. Home health care has increasingly become a long-term care benefit, with three-quarters of all home health payments in 1994 being provided to patients whose episode of care was at least four months. Many SNF patients also have chronic care needs, and they may cycle through acute, post-acute, and long-term care services covered by both Medicare and Medicaid. Thus, limiting payment for, or use of, particular post-acute care services financed by Medicare could lead to increased federal spending elsewhere.

Payment Options

Most proposals to slow the growth of Medicare spending on post-acute care services focus on payment options. Those proposals generally would tighten current Medicare payment systems in the near term, allowing time to develop alternative payment methods to be put in place in several years.

Tightening current payment systems is perhaps the simplest way to reduce the growth of spending for post-acute care services under HI. Those systems generally pay each provider on a cost-reimbursement basis, subject to a limit (see Box 1). Cost limits could be pared, or they could be imposed where particular costs (such as ancillary services in SNFs) are not now subject to a limit. Although such an approach could be useful in the near term, cost-based payment provides little incentive to reduce the use of health services.

Replacing cost-based reimbursement with prospective payment may be a more promising avenue of reform. Developing a workable payment system that could control growth in the volume of services provided, however, would be complicated. By fixing the payment for a set of related services, prospective payment systems place providers at financial risk for the services they either provide directly or order for patients. Unlike the current payment system, prospective payment can give providers an incentive to hold down their costs. But prospective payment systems also encourage providers to increase the number of beneficiaries using services, while minimizing the care provided to those patients.

BOX 1
POST-ACUTE CARE BENEFITS FINANCED BY THE HOSPITAL INSURANCE PROGRAM

Services provided by skilled nursing facilities (SNFs) and home health agencies account for most Hospital Insurance (HI) payments to fee-for-service providers of post-acute care services—roughly five-sixths of the total in 1995. In addition, the HI program finances inpatient stays in rehabilitation hospitals, rehabilitation units within acute care hospitals, and long-term hospitals.

SNF Benefit. Medicare pays for up to 100 days of SNF care during a spell of illness for beneficiaries who recently have completed a minimum three-day hospital stay and need skilled nursing or rehabilitation services on a daily basis. A copayment equal to one-eighth of the hospital inpatient deductible is required from the beneficiary, beginning on the 21st day of SNF care. That copayment is $95 in 1997.

Medicare pays SNFs separately for routine services, capital costs, and ancillary services. Payments for routine services (which include room, board, and skilled nursing services) are based on facility-specific costs subject to national limits. Payments for capital and for ancillary services (such as physical therapy, occupational therapy, speech therapy, laboratory tests, and pharmacy) are based on the facility-specific costs without limits.

Home Health Benefit. To qualify for the home health benefit, enrollees must be homebound and require skilled nursing care or physical or speech therapy on a part-time or intermittent basis. Beneficiaries may also receive occupational therapy, home health aide services, or medical social services. A previous hospital stay is not required to receive the home health benefit. Medicare reimburses agencies for their costs up to aggregate agency limits, which are based on per-visit cost limits for each type of home health service. The per-visit cost limits are 112 percent of the average cost per visit for free-standing agencies. Limits are calculated separately for urban and rural providers. There is no copayment for beneficiaries.

Rehabilitation and Long-Term Hospital Benefits. Rehabilitation facilities—free-standing hospitals or distinct-part units within acute care hospitals—and long-term hospitals are exempt from the hospital PPS and are paid on a cost basis subject to limits. Patients in rehabilitation facilities require intensive treatment (at least three hours of therapy a day, frequent direct physician involvement and 24-hour rehabilitation nursing). Long-term hospitals provide a wide range of services, including rehabilitation, treatment of ventilator-dependent patients, cancer treatment, and chronic disease care. The average inpatient stay in long-term hospitals must exceed 25 days. For both rehabilitation and long-term hospital benefits, patients are subject to the HI hospital deductible ($760 per spell of illness in 1997) and daily coinsurance for the 61st through 90th days ($190 a day in 1997).

A prospective payment system would have to be designed carefully to assure that Medicare savings were obtained without jeopardizing access to or quality of care, and without imposing undue financial risk on providers. Important design features include the scope of services covered by prospective payment and the selection of appropriate adjusters to better match payments with the cost of providing treatment.

Scope of Services. In principle, greater program savings would be likely to result from prospective payment systems that pay for a broader range of services over an entire episode of care, rather than more narrowly defined services provided over a limited period of time. A broad definition would encompass more fully the care needed to treat a patient's illness, and would limit the provider's opportunity to receive additional payments by shifting necessary services outside the defined episode.

The most encompassing prospective payment system for post-acute care services would pay hospitals a prospective "bundled" rate to cover both inpatient and all post-acute care, including SNF, home health, and rehabilitation services. Such an approach would encourage more efficient use of services over a broadly defined episode of care. It would also eliminate the financial incentive that now exists with separate payments for hospitals and various types of post-acute care providers to discharge patients from an inpatient stay to another provider as soon as possible. But bundled payment has been criticized as putting too much control over treatment and financing in the hands of hospitals, and it would not address the growing use of home health services that do not follow an inpatient stay.

Separate prospective payment systems for SNFs, home health agencies, and rehabilitation units have also been proposed. Those systems would encourage individual providers to reduce the cost of services they deliver. But separate prospective payments would introduce a new incentive for post-acute providers to discharge patients to another provider as soon as possible. Shifting patients among post-acute care providers is more likely if, as appears to be the case, the services they offer are close substitutes. Such shifting could adversely affect both the quality of patient care and the savings possible under a new payment policy.

Payments would no longer be tied to the costs of individual providers under a prospective system, and separate billing would be eliminated for some or all of the services and supplies provided. A prospective payment system for SNFs, for example, might cover routine costs (including room and board and routine nursing care), capital costs, and ancillary costs (including therapy services, drugs, and medical supplies). Payment might be for one day of care or for an episode, such as an uninterrupted stay in an SNF.

Prospective payment systems using smaller units of service, such as days or visits rather than episodes, are not likely to yield substantial program savings. For example, paying home health providers on a per-visit basis would allow providers to increase revenues by reducing the services provided in a visit, necessitating more home health visits.

Even per-episode prospective payment systems-either under a bundling approach or separate prospective systems-might not yield program savings if they were poorly designed. Such systems encourage "cream skimming," in which providers seek out low-cost beneficiaries with few post-acute care needs. The full prospective payment could be substantially greater than the amount that would have been paid under the current cost-reimbursement system, unless the payment was adjusted to reflect the level of the patient's need for services.

If the prospective amount did not accurately reflect the cost of providing care, high-cost patients might face restrictions on their access to providers. Those providers who served sicker patients or who operated in higher-cost areas could risk financial losses even if they were run efficiently, unless appropriate adjustments were made to the payments.

Payment Adjusters. Risks to providers and beneficiaries could be reduced by adjusting payments to match more closely the cost of providing necessary treatment. Although the focus of attention has been on developing case-mix adjusters, which reflect cost variations in the treatment of similar patients, a practical prospective payment system for post-acute care services would probably also require payment adjusters to reflect cost factors that are specific to the institution.

The hospital PPS, for example, uses three kinds of payment adjustments: diagnosis-related groups (DRGs), outlier payments, and hospital-specific adjustments. DRGs adjust the Medicare payment for case mix, assuring that payments are higher for patients needing more expensive care. A DRG payment represents the average cost of treating patients with a given diagnosis. Medicare also makes an outlier payment when a particular patient requires much more extensive services than is typical for his or her DRG. Additional adjustments are made to payment levels to reflect

factors that could indicate higher operating costs, such as teaching status or an index of hospital wages in the local area.

Developing an adequate case-mix adjuster for post-acute care services would be complicated, since the need for medical services is only one factor determining the cost of a patient's care. In addition, the functional status of a newly discharged patient and the availability of family support help determine both the type of post-acute care that may be needed and its duration and expense. The more a patient needs help bathing, walking, or engaging in other activities of daily living, and the less help he or she might have at home from family members, the more likely the need for post-acute care.

Assessing patient needs would be difficult and probably subjective, however, and would be only the first step in designing a case-mix adjuster. The Health Care Financing Administration (HCFA) has worked for some years to develop assessment instruments, including the Uniform Needs Assessment Instrument, the long-term care facility minimum data set, and the Outcomes and Assessment Information Set (known as OASIS).

To develop a case-mix adjuster, data from patient assessment systems would be used to classify post-acute care patients according to the cost of the services they use. HCFA has been testing various case-mix systems over the past decade. Research in the late 1980s, for example, suggested that DRGs might be a basis for adjusting bundled payments for case mix. The Resource Utilization Groups III (RUGs-III) system for SNF services has been tested in the Nursing Home Case Mix and Quality Demonstration that began in 1989. HCFA also continues to develop prototype case-mix adjusters for home health care, but it has not yet determined an appropriate unit of service on which to base a separate prospective payment system.

Developing adequate case-mix adjusters remains a challenge for any proposal to institute prospective payment for post-acute care services. We have to rely on information from current patterns of service use, but those data include both inappropriate use and fraudulent claims. Even if all fraudulent claims could be eliminated from the analysis, the resulting costs of service would potentially be much higher than they would be under a more efficient payment system. One could, for that reason, justify reductions in payments to post-acute care providers even after payment reforms were introduced.

Other Policies

Although prospective payment systems might help constrain expenditures on post-acute care services, those systems alone would not necessarily slow the growth in the number of people using post-acute care. Given the incentives encouraging hospitals under the PPS to discharge patients as soon as possible, the lack of clear and enforceable standards to determine the services that patients should receive opens the door to continued increases in admissions to skilled nursing facilities. Medicare has even less control over the use of the home health benefit, which does not require prior hospitalization and does not require the patient to leave familiar surroundings. As a result of such factors, if providers admit new patients who require only a small amount of care, prospective payment systems for post-acute care services might not generate savings and could even increase program costs.

The larger policy question, however, is the proper role of Medicare in financing long-term care. Medicare was originally conceived as an acute care insurance program. The home health benefit has been reinterpreted to cover both patients who need true post-acute care and those who need chronic care. Tightening coverage standards would probably restrict that benefit more closely to its original concept. But a reconsideration of Medicare's role might instead lead to expanded coverage of long-term care, if policymakers concluded that the program should provide chronic care benefits.

Imposing a realistic cost-sharing requirement on home health services might be an alternative to cutting back Medicare's coverage of those services. Home health care is the only Medicare service, aside from clinical laboratory services, not subject to cost sharing. Imposing such a requirement could give beneficiaries a greater awareness of the services for which Medicare is being billed. Cost-sharing would also yield some program savings since part of the cost of services would be shifted to beneficiaries.

Whether such a policy would lead to a decline in the use of services depends on whether the new cost-sharing requirement was covered by Medigap and employer-sponsored insurance. The Congress could prohibit Medigap plans from covering those new requirements, for example, to enforce financial incentives that would discourage use of home health services. Employer-sponsored plans might not cover home health coinsurance, since few of those plans offer any form of home health cov-

erage now. Low-income beneficiaries for whom Medicaid was paying for Medicare cost-sharing requirements would continue to receive that protection.

THE PRESIDENT'S 1998 BUDGET PROPOSALS

The budget the President submitted for fiscal year 1998 includes proposals that would lower spending on services from post-acute care providers paid on a fee-for-service basis under the HI program by $27.6 billion over the next five years, compared with current law (see Table 5). Those proposals are part of a broader package of reductions in spending and expansions of benefits that, on net, would reduce Medicare spending by $82 billion between 1998 and 2002, according to CBO estimates. In addition, the Administration proposes to transfer spending for certain home health visits from the HI program to the SMI program.

TABLE 5.—SAVINGS ON POST-ACUTE CARE SERVICES UNDER THE PRESIDENT'S 1998 BUDGET

(By fiscal year, in billions of dollars)

Reductions in Payments to Fee-For-Service Providers [1]	1998	1999	2000	2001	2002	Cumulative Savings, 1998–2002
Skilled Nursing Facility	0.1	1.3	1.8	2.1	2.4	7.6
Home Health Agency	1.1	1.4	2.9	3.4	3.9	12.8
Other [2]	0.9	1.2	1.5	1.7	1.9	7.2
Total	2.1	3.9	6.2	7.2	8.2	27.6

SOURCE: Congressional Budget Office.

[1] Includes only payments from the HI program.

[2] Includes a recalibration of hospital payments when a patient is transferred, a moritorium on new long-term hospitals, and reduced payment updates and capital payments to hospitals exempt from the prospective payment system.

Proposed SNF Policies

The Administration proposes to establish a prospective payment system for SNF services that would make payments on a per-day basis for all costs of SNF services-routine service, ancillary service, and capital costs. Payments would be adjusted for geographic differences in wages and for case mix. The case-mix adjuster is not specified in the proposal, but it is likely to be the RUGs-III system. During a four-year transition period, payments to SNFs would be a blend of the national payment amount and an amount specific to the facility, both of which would be prospectively determined. Those policies would become effective on July 1, 1998.

A per-day prospective payment system might be a practical way of addressing the burgeoning costs of ancillary services in SNF treatment. Unnecessary use of those services during a day of care would be discouraged, although the number of days of SNF care might increase. As noted earlier, SNF payments have been driven by the growth of both ancillary costs and the number of users, with the average number of SNF days per patient remaining fairly stable. However, per-day payment could spark some increase in the average length of stay in SNFs and would not control growth in the number of users.

Although a more inclusive per-episode payment would provide broader incentives to hold down treatment costs, case-mix adjusters would be needed that could reliably predict the variation in those costs for entire episodes. HCFA has focused its efforts, instead, on developing adjusters for per-day payment.

The Administration's proposal would also reduce the annual update to limits on routine service costs by removing the effects of spending growth that occurred between July 1994 and July 1996. In addition, to eliminate fraudulent billing practices, SNFs would be required to bill Medicare for nearly all services their residents receive. Outside suppliers of those services could no longer bill Medicare separately.

Proposed Home Health Policies

The Administration's proposals for Medicare's home health benefit include adjusting the current payment system to slow the growth of spending, introducing a prospective payment system based on those reductions in payments, and making some changes in the way the benefit is administered.

An interim payment system would be established for home health services, beginning on October 1, 1997. That system would pay home health agencies the lesser of actual cost (defined as Medicare allowable costs paid on a reasonable-cost basis), a per-visit cost limit (based on 105 percent of national median costs), and a new limit that is specific to the agency on annual costs per beneficiary (based on reasonable costs reported by the agency for 1994). The agency-specific limit on per-bene-

ficiary costs is intended to account for the recent rapid growth in the volume of home health visits provided to patients.

A prospective payment system would replace the interim system, beginning on October 1, 1999. The details of that prospective payment proposal, however, are largely unspecified. The unit of service for which payment would be made is not stated in the proposal. Although payments would be adjusted for case mix and labor costs, no specific case-mix adjuster is identified. An outlier policy is proposed, but the details are left to the Secretary of Health and Human Services. Program savings would be the result of a 15 percent reduction in the cost limits and per beneficiary limits that are in effect on the last day before the policy is carried out.

In addition, home health cost limits would be cut by removing the increase in the market basket that occurred between July 1994 and July 1996. Other policies would base payment on the location where services are rendered, not where services are billed. Periodic interim payments would be eliminated when the prospective payment system is put in place. So-called normative standards would establish a basis for claims denials, and the definition of "homebound" would be clarified.

The President's budget also proposes to shift part of home health care from the HI program to the SMI program. Beginning October 1, 1997, the first 100 visits following a three-day hospital stay would be reimbursed under HI. All other visits, including those not following hospitalization, would be reimbursed under SMI. Those latter visits would not be subject to the SMI deductible or coinsurance, and would not increase the SMI premium. About $86 billion in payments would be shifted from HI to SMI. The transfer would have no impact on total Medicare spending, but it would postpone depletion of the HI trust fund. CBO estimates that the Administration's policies, including the home health transfer, would maintain a positive balance in the HI trust fund through 2007.

Other Proposals

Because the number of long-term hospitals has grown rapidly in recent years, the Administration proposes to stop designating new long-term hospitals. Much of that growth is the result of rehabilitation and psychiatric hospitals changing designations to avoid Medicare's more stringent criteria for the coverage of services. In addition, some acute care hospitals have converted part of their facilities into separate long-term hospitals.

Payment rates for non-PPS hospitals would also be reduced. Limits on operating costs would be rebased, and capital payments would be reduced to 85 percent of reasonable costs.

In addition, the Administration would change the payment policy for patients discharged from PPS hospitals to SNFs or non-PPS hospitals. Under current rules, the PPS hospital receives a full DRG payment for those patients, and the SNF or non-PPS hospital also gets its normal payment. The proposal would treat those patients as transfers, with the PPS hospital paid on a per-diem basis up to the full DRG payment.

CONCLUSION

Reining in the spending on post-acute care services in Medicare would be a formidable task. The current payment structure of fee-for-service Medicare fails to give post-acute care providers an incentive to constrain spending, and past actions that broadened the benefit beyond true post-acute care have greatly contributed to the growth of program spending. Within this context, it is difficult to design policy options to slow the growth of spending.

Because the financial incentives facing post-acute care providers are complicated, the effort required to develop a workable new payment system would be substantial. Options that would limit spending by one type of provider could result in a shift of spending elsewhere in the Medicare system, particularly when services offered by other providers are close substitutes. The Administration's proposals represent a first step on what is undoubtedly a long road to payment reform for post-acute care services.

PREPARED STATEMENT OF MARGARET CUSHMAN

Mr. Chairman,

Thank you for the opportunity to present testimony today on issues related to the Medicare home care benefit. My name is Margaret J. Cushman. I am the President of VNA Health Care in Hartford-Waterbury, Connecticut. I also chair the Government Affairs Committee of the National Association for Home Care (NAHC), as well as serve on the NAHC Prospective Payment System (PPS) Task Force.

The National Association for Home Care is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's members are every type of home care agency, including nonprofit agencies, like the Visiting Nurse Associations, for-profit chains, hospital-based agencies and freestanding agencies.

NAHC is deeply appreciative of the attention PPS for home care has received from this Committee. We have been advocating such a system for more than a decade. Congress, too, has been pushing the Administration for development of a PPS for home care for many years. We were very pleased that proposals to implement such a system were included in the balanced budget plans offered in the last Congress by both parties, and that a PPS plan was passed by the full Congress as a part of HR2491, the Seven Year Balanced Budget Act (BBA) in lieu of copays.

I'd like to ask permission, Mr. Chairman, to have my full written statement, along with the following attachments, included in the hearing record:

- o a chart showing the characteristics of Medicare home care patients,
- o a copy of a declaration in support of the industry's unified PPS plan signed by home health associations in all 50 states and major national associations,
- o a detailed description of the industry's Revised Unified Plan.

My testimony is organized as follows:

- o factors affecting growth in home care,
- o concerns about and efforts to address fraud and abuse,
- o discussion of PPS, and
- o discussion of the President's FY98 budget proposals and other proposals that affect home care.

I. FACTORS AFFECTING GROWTH IN HOME CARE

Home care encompasses a broad spectrum of both health and social services that can be delivered to recovering, disabled or chronically ill persons in their homes. These services include the traditional

core of professional nursing and home care aide services as well as physical therapy, occupational therapy, speech therapy, and medical social services.

Generally home care is appropriate whenever a person needs health care assistance that cannot be easily or effectively provided solely by a family member or friend for a short or long period of time. There are many situations and conditions for which home care services are especially appropriate. Technology advancements mean that every day more people are able to be cared for effectively and efficiently at home even if they have illnesses that, at one time, were only treatable in hospitals or institutions.

The home health benefit has been an evolving benefit for most, if not all, of its existence in the Medicare program. In Medicare's earliest years, home health expenditures amounted to only about 1% of the total. Today, approximately 9% of total Medicare payments are made for home health services. Therefore, while the benefit has increased each year, it still represents a small proportion of Medicare spending.

In 1996, nearly 4 million Americans received Medicare home health services, representing an estimated $18 billion in Medicare spending. Much of the increase over time can be attributed to one-time expansions or clarifications that were specifically designed to allow more individuals access to additional in-home services.

Home health growth, however, is expected to moderate and fall to more modest levels in the next few years. The HCFA Office of the Actuary expects annual growth in the volume of visits to steadily decrease to around 6% through the year 2000.

Reductions in Hospital Lengths of Stay Growth in the home health benefit must not be looked at in isolation. There is a direct connection between the effect of PPS on hospitals and the growth in the home care benefit. PPS has made it in the hospitals' best interest to move patients out of hospitals as soon as possible, and to collect the full DRG payment for fewer days of care. In fact, over the last six years, lengths of stays in hospitals fell 31% in the DRGs most associated with post-acute care use. Average costs per discharge also declined about 6% during the same time period.

Despite a decade of continual reductions in the hospital lengths of stay, the Medicare hospital updates have never reflected these changes. Decreases in the hospital lengths of stay should be reflected in Medicare payments to hospitals. In the President's FY98 budget, home health and other post-acute care providers are penalized for the growth in their areas that have been fueled by hospitals. Hospital payment rates should be reduced to reflect this change, rather than hitting home care and other post-acute care providers.

Several other factors explain the growth in the home health benefit not associated with quicker discharges of more acutely ill patients from hospitals.

Coverage Clarification In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be covered. The

result was a "chilling effect" in which some Medicare covered claims were diverted to Medicaid and some patients went without care. This "denials crisis" led in 1987 to a lawsuit (*Duggan v. Bowen*) brought by a coalition led by Representative Harley Staggers and Representative Claude Pepper, consumer groups and NAHC.

The successful conclusion of this suit led to a rewrite of the Medicare home health payment policies. Just as lack of clarity and arbitrariness had depressed growth rates in the preceding years, the policy clarifications that resulted from the court case allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended.

The correlation between the policy clarifications and the increase in visits is unmistakable. The first upturn in visits (25%) came in 1989 when the clarifications were announced; and an even larger increase took place (50%) in 1990, the first full year the new policies were in effect.

Cost Effectiveness Home health has moved well beyond its traditional boundaries, making it possible for patients to prevent, reduce or eliminate altogether their need for more costly inpatient treatment. It is also important to note that while growth in home care has been experienced in the number of visits provided per patient, home care's costs have remained steady over the last decade, making home care still one of the best health care buys.

An Aging Population The aging of the U.S. population will continue to influence future need for home health services. Older individuals are more likely to need home care and they are likely to use more home care services than younger home health patients. For example, the National Medical Expenditures Survey found that individuals over age 85 are three times more likely to use home care as the general elderly population, and their resource consumption was also significantly higher. Individuals over age 65 used an average of 65 visits whereas individuals over age 85 used an average of 75 visits.

Improved Access Throughout much of the 1980s, the home care industry, along with the rest of health care, was experiencing a personnel shortage. Although there are still acute shortages of certain disciplines, conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to 9,923 in 1996. Although access varies somewhat from state to state, for the most part enrollees who need home health care now have access to it.

Public Awareness and Preference The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery for health care services. For example, a 1985 survey found that only 38% of Americans knew about home care; by 1988, over 90% of the public understood home care to be an appropriate method of delivering health care, and supported its expansion to cover long-term care services as well. A 1992 poll found that the American public supports home care by a margin of nine to one over institutional care. Nearly 82% of all accredited medical schools now offer home health care training in their curricula.

Technological Advances Over the years, sophisticated technological advances have made possible a level of care in the home that previously was only available in hospitals and other institutions. The most significant of these advances has been the introduction of home infusion therapy and radical improvements in ventilator equipment.

Reductions in home care spending are likely to result in greater Medicare expenditures for hospital inpatient and emergency care, physician services, and nursing home care. Home health care serves as the safety net for patients who are discharged from acute and rehabilitation hospitals after shorter lengths of stay.

II. CONCERNS ABOUT AND EFFORTS TO ADDRESS FRAUD AND ABUSE

As in any area, growth brings with it the potential for unethical or illegal behavior. NAHC strongly believes it is the responsibility of all parties involved -- patients, payors, and providers -- to act aggressively to uncover, report, and act against fraudulent or abusive home care providers.

NAHC has taken a leadership role in combatting fraud and abuse. It has been engaged in a longstanding effort to maintain the highest degree of ethics and values in the health care industry through a combination of member education, cooperation with and assistance to enforcement agencies, and consistent support of federal legislative proposals designed to combat abuses in health care programs.

In January 1994, NAHC implemented a broad new policy governing member conduct. While America has enhanced home care as the site of choice for meeting its health care needs, the growth of the industry has unfortunately been accompanied by a few unscrupulous providers of care who seek only to profit illegally at public expense. The incidence of established fraud in home care services is low. However, even a single occurrence of fraud or abuse is not acceptable and must be eliminated.

The principles of NAHC's policy are as follows:

1. POLICY ON MEMBER SELF-REGULATION

Where a NAHC member, agency, individual member, or an applicant for membership has been determined or is controlled by an individual who has been determined to have violated a criminal or civil law in either Federal or State Court on issues related to fraud and abuse, the NAHC Board of Directors may consider the imposition of sanctions, including the termination or rejection of NAHC membership.

2. POLICY ON PUBLIC RELATIONS

NAHC shall respond proactively and reactively to any public relations crisis concerning fraud and abuse activity in home care and hospice.

3. **POLICY ON EDUCATION OF MEMBERS**

Consistent with its mission and commitment to provide educational opportunities for members, and for the purposes of promoting standards of quality and ethics in the delivery of home care and hospice services, NAHC will provide education regarding issues of fraud and abuse in home care and hospice.

4. **POLICY ON ENFORCEMENT**

It is the responsibility of any NAHC staff person or any NAHC member to report to the appropriate legal authority any violation of fraud and abuse laws. No report shall be made by NAHC staff except where sufficient information has been obtained which demonstrates that there is a substantial likelihood that the law has been violated. Witnessing or having knowledge of a crime and not reporting it would constitute unethical behavior.

When government enforcement officials fail to act to address flagrant violation of the fraud and abuse law, NAHC may bring a civil enforcement action against the unscrupulous provider where authorized by a super majority of the Board of Directors.

5. **POLICY ON SUPPORTING FRAUD AND ABUSE LEGISLATION**

NAHC shall actively support and/or initiate legislative and regulatory measures appropriate to prevent or combat fraud and abuse in the home care and hospice industries.

6. **POLICY ON REQUEST FOR ASSISTANCE**

NAHC's assistance to member agencies under investigation for health care fraud and abuse shall be available only when it is determined that it is the best interests of the home care and hospice industry at large.

This policy is the embodiment of the NAHC efforts since its inception in 1983. Its enactment in 1994 was an affirmation of NAHC's commitment to maintain a leadership role in this troubling area. Evidence of NAHC's commitment is most evident in support of legislative efforts to control fraud. In 1993 and 1994, and continuing today, NAHC has publicly supported and worked to advance legislation which would expand existing health care fraud laws under Medicare and Medicaid to all payors in health care. This expansion would work to eliminate activities which escape scrutiny because of the lack of controls in certain states which allow for conduct with private health insurance payments that would be illegal if federal payments were involved. NAHC has also aggressively supported the creation of a private right of action under federal anti-kickback laws to supplement the limited resources of government enforcement agencies. In this same respect, NAHC has repeatedly supported increased funding for the Office of Inspector General at HHS.

Legislation is also needed to control the quality and delivery of home infusion therapy services. This $3 billion segment of the home care industry operates under virtually no regulatory controls and presents an environment for improper, but not necessarily illegal, conduct to occur. In 1994, NAHC

highlighted the need for controlling legislation such as that offered by Congressman Sherrod Brown in the so-called "Sara Weber" bill.

Fraud has also existed within the Medicaid programs. The states' Medicaid anti-fraud units have proven success in attacking this area. NAHC has and continues to support the continuation of these programs.

Legislation alone cannot control fraud and abuse. Health care providers must have a comprehensive understanding of the standards of conduct that are allowable. Internal self-audit and self-enforcement must be done to minimize the risk of illegal activities. Over the past several years NAHC has provided extensive education on the issues involved in health care fraud. National workshops have been held at our regional conferences, annual meetings, and annual law symposiums. State home care associations have joined in this effort to extend this education to the greatest degree possible.

NAHC believes that increased public awareness is a valuable means of oversight and that the public must be fully involved in the process of fighting fraud. It is the health care consumer and the taxpayer who are ultimately the injured parties. While the government should increase the information it provides to the public about known schemes and scams, the health care industry must also do its part. In accordance with the NAHC fraud and abuse policy, the home care industry has not only cooperated with media investigations but has worked to engage the attention of the media to focus on important areas of concern.

One of the most important roles that the home care industry plays in eliminating fraud and abuse is to lend its knowledge and expertise to enforcement authorities. Over the years, NAHC has acted as an extension of the investigatory arm of federal and state enforcement authorities. On the simplest of levels, NAHC has put individuals and providers of services who have evidence of fraudulent conduct in touch with the HHS Office of Inspector General. On a deeper level, NAHC has provided guidance to enforcement authorities on areas in which resources might be targeted in their home care efforts.

Historically, fraud and abuse in health care has taken the form of false claims in Medicare cost reports, billings for services never rendered, and kickbacks for referrals. These types of fraud are now being replaced with an entirely different form of abuse found in managed care. While in the traditional fee-for-service system incentives exist for overutilization and overcharging, managed care may create financial incentives to improperly underutilize care. The health care consumer is harmed doubly in these circumstances; financially, care is prepurchased but not delivered; and healthwise, necessary care is lost. NAHC strongly recommends that Congress and the enforcement authorities take a long hard look into the abuses in managed care. New strategies must be developed to address this new type of fraud. Clinicians, rather than accountants, will need to operate at the heart of this effort. Good managed care can help bring about economy and efficiency in health care. Bad managed care, controlled by financial greed, can mean the death of the patient.

Recommendations to Combat Fraud and Abuse

During the 104th Congress, NAHC played an active role in helping shape an anti-fraud health care package. Ultimately, these proposals were incorporated into the Health Insurance Portability and Accountability Act, P.L. 104-191, that was passed into law.

Passage of the anti-fraud package marks a good first step in eliminating waste, fraud and abuse in our health care system. There are, however, some specific issues within home care that need to be addressed by anti-fraud legislation.

Congress should continue its work in combating waste, fraud and abuse in our nation's health care system by passing a home care specific anti-fraud package that includes:

* **Limiting Agencies' Ability to Subcontract Care.** Medicare certified home health agencies should be allowed to utilize only a limited amount of subcontracted care for the dominant health care service, such as nursing, which they provide.

* **Mandating Freedom of Choice Information.** Hospitals, physicians, and other health care providers, should be required to give patients full information about the availability of Medicare certified home health agencies serving the areas in which the patients reside, and should be prohibited from steering patients to certain agencies.

* **Prohibiting Home Health Agencies from Assisting Physicians in Care Billing.** Home health agencies should be prohibited from providing record keeping and bill preparation services to physicians for their role in home care.

* **Requiring Home Health Care Administrators to Meet Certification and Accreditation Standards.** The last several years have seen an unbridled growth in the number of Medicare certified home health agencies. Home care agency administrators should be required to meet high and rigorous standards for all aspects of running an agency, including issues that affect quality of care.

III. PPS FOR HOME CARE

Congress has before it a unique opportunity to work closely with the home care community to improve the Medicare home care benefit. The Revised Unified PPS plan offered to Congress by the home care industry and introduced by Representative Nancy Johnson (HR4229) incorporates the best elements of the home care PPS provisions in the Balanced Budget Act (BBA) passed by Congress and HR2530, the Blue Dog Coalition's budget plan introduced in the 104th Congress.

The Revised Unified PPS Plan represents the most advanced thinking that's been done in developing a PPS plan. It also represents a substantial improvement over the current Medicare cost-based reimbursement system.

Let me be very direct regarding the context in which we are offering this PPS proposal. In 1995, Congress proposed sizable savings from the Medicare program, a portion of which was to come from home care. Since the industry found copayments and bundling unacceptable, Congress challenged us to develop a more acceptable way of achieving the required savings. This PPS proposal was developed as an alternative to home care copays, bundling, and other onerous ideas, and that is the context in which we are offering it today.

Our goal was to develop a PPS plan that 1) the home care industry could support, 2) would use the best that both the Republican (BBA) and Democratic (HR2530) plans had to offer, 3) would address concerns raised about the PPS plans in both the BBA and HR2530, 4) would accommodate deficit reduction requirements, 5) would substitute for home care copays and bundling, and 6) would address HCFA's concerns about feasibility of implementation on a timely basis.

Advantages of PPS

PPS offers numerous advantages to the Medicare program over the current cost-based reimbursement methodology. Under current law, home health agencies are reimbursed for the allowable costs which they incur in caring for Medicare patients up to a per visit cap. Cost reimbursement, however, has been criticized because it is complex and costly to administer, because the amounts that are paid are subject to disallowance and recoupment long after the services have been rendered and because it offers no incentives for provider efficiency.

PPS, by providing desirable, market-like incentives that encourage the efficient and effective provision of care, would avoid these problems because payment rates would be established in advance.

PPS, by providing financial incentives for home care agencies to reduce both visit and total case costs, will achieve Medicare savings without restricting beneficiary access to high quality home care services. PPS properly places the burden to be efficient in the provision of care on providers and not beneficiaries. Alternatives to PPS, like copayments and bundling, create barriers to high quality home care services by increasing a beneficiary's out-of-pocket expenses and restricting access to post-acute care services.

Revised Unified PPS Plan

The Revised Unified PPS Plan that we are testifying in support of today is a modification of the original unified plan submitted to Congress in 1995.

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. Our goal was to develop an episodic system which would:

- o be developed cooperatively by HHS, the industry, and Congress,

- o be acceptable to the industry,
- o include extended care,
- o be submitted to Congress one year in advance of implementation, and within four years of enactment of legislation,
- o be implemented only after Congressional approval,
- o include adjustments for new requirements (such as OSHA) or changes in technology or care practices,
- o be based on a case-mix adjuster that reflects the differences in cost for different types of patients,
- o prevent the imposition of home care copays, bundling, or other benefit limits,
- o implement a per-episode PPS as soon as possible, and
- o do as little harm as possible to home care patients and providers in implementing an untested system.

This plan, which represents years of work and refinement by the home care industry, calls for a three-phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case-mix adjuster and would require the development, within five years, of a per-episode PPS with a case-mix adjuster that adequately distinguishes the cost of providing services to various types of patients.

Phase 1 of the Plan would implement a prospectively-set standard per-visit payment with an annual aggregate per-patient limit that applies to all visits. Phase 2 would put in place prospectively set standard per-visit payments with an annual aggregate episode limit for days 1 - 120 and an annual aggregate per patient limit for visits after 120 days. Phase 3 puts in place a per-episode PPS.

This PPS plan would give home care providers incentives to reduce costs and increase efficiency through a provision in which they would be allowed to keep a portion of the difference between the total per visit payments and the agency's annual aggregate cap. This provision differs from the way PPS for hospitals was implemented, in which hospitals are allowed to retain the entire difference between the DRG payment rate and the cost of care. Under the revised unified PPS proposal, home care providers would be allowed to retain 50 percent of the difference, up to a cap, with the balance of the savings used for the exceptions process.

Scoring

NAHC has been working with the accounting firm of Price Waterhouse in reviewing the potential cost savings available through this proposal. We believe it to represent savings roughly equivalent to the savings offered under the Administration's PPS proposal and have built into the proposal a number of components that can be adjusted to achieve necessary savings.

We are deeply concerned about certain assumptions the Congressional Budget Office has employed in scoring PPS proposals for home care. In assessing the prospective payment proposal included in HR2491, CBO imposed a 66 2/3% offset that had the effect of dramatically reducing potential savings the proposal could have achieved. This offset reflects CBO's assumptions of behavioral changes on

the part of home health care providers in response to this proposal, as well as their assumption of the proposal's effectiveness.

CBO used this two-thirds offset to calculate net savings for the home health prospective payment provision, meaning that the sum of gross savings for each provision of the proposal was reduced by two-thirds. Under this offset, a proposal scored at $14.2 billion in savings over seven years, as was the PPS proposal in the BBA, actually would reduce Medicare home health expenditures by $42.6 billion over seven years, or three times the scored amount.

Never before, to our knowledge, has CBO employed such a dramatically high assumption of gaming. An offset of this magnitude is entirely unjustified and makes it much more difficult for home care to present a proposal offering necessary savings that does not inflict great hidden harm to home care beneficiaries.

History of PPS

NAHC has long supported the development of a prospective payment system for home care. NAHC championed the initial PPS demonstration legislation that Congress passed in 1983 as part of the Orphan Drug Act (P.L. 97-414). In that legislation, Congress required the Medicare program to test alternative reimbursement methodologies to determine the most cost effective and efficient way of providing care, including fee schedules, prospective payment, and capitation payments.

Following the passage of this legislation, the industry, through the National Association for Home Care, created its first Prospective Payment Task Force. When the demonstrations authorized under that legislation were held up in 1985 by the Office of Management and Budget, NAHC stepped in and partially funded the Georgetown University study on patient classification.

The U.S. Department of Health and Human Services (DHHS) did not undertake any serious effort to follow through with the study required in the 1983 legislation. Accordingly, the industry sought a stronger mandate from Congress.

With the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Congress required that DHHS design a prospective payment demonstration in a manner that would enable the Secretary to evaluate the effects of various methods of prospective payments (including payments on a per visit, per case, and per episode basis) on program expenditures, as well as beneficiaries' access to care. An interim report was required by Congress within one year after enactment of the legislation. A final report was due four years after enactment. The demonstration was set to begin no later than July 1, 1988.

The Health Care Financing Administration (HCFA) was unable to move the demonstration project forward on a timely basis and sought a delay from Congress. As part of the Medicare Catastrophic Protection Act of 1988, OBRA-87 was amended to modify the effective date from July 1, 1988, to April 1, 1989.

After nearly three years with limited effort by DHHS, Congress, at the request of the home health

industry, once again intervened in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Congress directed HCFA to research and report back to Congress on whether to move cost-based providers, including home health agencies, to some form of alternative reimbursement. DHHS was required to submit a report to Congress that included a proposal for prospective payment for home health agencies by September 1, 1993. The Prospective Payment Assessment Commission was to analyze the DHHS proposal and report to Congress by March 1, 1994.

In developing this proposal, DHHS was required to:

(1) provide for appropriate limits on home care expenditures;

(2) account for changes in patient case-mix, severity of illness, volume of cases, and the development of new technologies and standards of medical practice;

(3) consider the need to increase payment for outlier cases, those cases which exceed the average length or cost of treatment;

(4) address the varying wage-related costs among agencies; and

(5) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments.

Ultimately, HCFA initiated a two phase demonstration project to study prospective payment for home health services. In Phase 1, HCFA experimented with a per visit prospective payment methodology. That project, which concluded in 1994, found limited effect on the behavioral actions of home health agencies and expenditure through the use of a per visit method of reimbursement.

Phase 2 of the demonstration project was initiated in March, 1995. Phase 2 is intended to study the behavioral reaction to a per episode based prospective payment system using a case-mix adjustor that classifies patients into one of eighteen categories. As the result of the weaknesses of the case-mix adjustor, explaining only 9.7% of variation in costs for various types of patients, HCFA limited the focus of the demonstration project to analyzing behavioral changes for participant home health agencies. It is expected that a final report will be issued on Phase 2 of the demonstration project in either 1999 or 2000.

We would like to reiterate that the industry's Revised Unified PPS Proposal, while an improvement over the current cost-based reimbursement system, is being offered solely in the context of deficit reduction as an alternative to other home care savings proposals.

Some alternatives, including shifting some home care from Medicare Part A to Part B, placing copayments on Medicare home health visits, and bundling home care payments into hospital DRGs or other provider payments, would have serious detrimental effects on the nearly 4 million Americans who rely on quality home health care. Moreover, these proposals could severely limit access to home care, limiting health care choices for our Nation's elderly and disabled to more costly institutions.

We were extremely pleased that in the BBA, the Committee abandoned home health copayments and bundling in favor of a prospective payment system (PPS) as a way to ensure the efficient delivery of home care services.

IV. PRESIDENT'S FY98 BUDGET PROPOSAL

The provisions included in the Administration's FY98 budget package would have a dramatic impact upon the delivery of home health care under Medicare. Home care would be subject to a level of cuts which is disproportionate to its share of the Medicare program. Home health comprises 9.6% of total Medicare outlays, but would sustain 13% of the cuts requested by the President. For comparison purposes, skilled nursing facility payments now comprise about 6% of total Medicare outlays, but would sustain 7% of the cuts, which is much closer to its proportion of program outlays.

Beyond the depth of the home care cuts, NAHC has grave concerns about the overall effect of the Administration's budget on the future of the Medicare home health benefit. While the President's proposal puts forth a plan to implement a prospective payment system (PPS) for home care and takes a first step toward providing much-needed respite for informal caregivers of Medicare Alzheimer's victims, draft legislative language reveals proposals that would create two separate home care benefits under Part A and Part B of Medicare, impose arbitrary limits on home care and reverse hard-won legal battles which broadened availability of home care to deserving beneficiaries. Additionally, the proposed FY98 budget would grant broad Secretarial authority to deny payment for services which lie outside "norms of care" and to lump post-acute services into a single care payment.

Despite some benefit expansions, the proposed budget translates into very real reductions in access to home care services for needy Medicare beneficiaries.

Transferring Some Home Health Coverage From Part A to Part B of Medicare

Under the President's proposal, Part A would cover home health services only when both of the following conditions are met: (1) home health services are furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than three consecutive days before discharge, or during a covered post-hospital extended care stay, and (2) the home health services are initiated for such individual within 30 days after discharge from the hospital, rural primary care hospital, or extended care facility.

All other home health care services -- including services not following a hospitalization and services beyond 100 visits -- would be covered under Part B.

The additional home care costs transferred into Part B would not be used in calculating the Part B premium, which traditionally covers 25% of Part B program costs. Individuals who have Part A coverage only would continue to have all their home care services covered by Part A until 19 months after the date of enactment.

This proposal would do little to address the underlying insolvency issues facing the Part A trust fund. We are deeply concerned that this proposed shift will result in increased tax burdens on middle income families and increased costs to Medicare beneficiaries, and may deny needed home care services to millions of seniors and disabled individuals.

This shift would transfer up to $82 billion in costs directly onto taxpayers. The size of the increased burden on taxpayers resulting from this transfer would continue to rise over the years.

If Medicare beneficiaries were required to contribute to the costs of home care transferred to Part B, premiums have been estimated to increase by nearly 20 percent -- $8.50 per month in 1998, rising to $11.00 per month by 2002. The Part B monthly premium is already $43.80.

This transfer may also make the home care benefit more susceptible to beneficiary copays and deductibles. As a result, Medicare home health beneficiaries could be subjected to additional coverage restrictions that would further reduce the benefit. This proposal would decrease cost-effective medical benefits to millions of Americans at a time when the need for home care services is growing.

We are additionally concerned that 2.1 million elderly and disabled Medicare beneficiaries who are covered by Part A, but not by Part B, may lose access to much of the Medicare home care benefit under the President's proposal. Beginning 19 months after enactment, the benefit for these individuals would be limited to only 100 visits and only if the care began immediately following a hospital stay of at least three days or discharge from a covered extended care facility. To the extent that these individuals are either already Medicaid eligible, or would spend down to Medicaid due to increased health care costs, this provision would result in an increased burden on State Medicaid programs.

NAHC proposes, instead, fundamentally improving the way Medicare pays for home care services by enacting a prospective payment system (PPS) for home care.

PPS For Home Care

The Administration's PPS proposal included in the FY98 budget submission falls short of the industry's expectations in a number of ways.

The interim payment proposal essentially continues the present cost-based reimbursement system, while eliminating any savings sharing that gives providers incentives to reduce costs and increase efficiency. Both the Administration's previous plan, as well as HR 2491 (the Congressionally passed plan) and HR 2530 (the Democratic alternative) contained such incentives for providers. With the retention of cost reimbursement and the elimination of the savings sharing provisions, this plan contains little by way of incentives for providers to participate in creating more efficient operations.

The Administration's original proposal would have blended agency-specific limits with those of the census region. This provision was eliminated. Totally agency-specific limits tend to maintain previous behaviors, both good and bad, and could penalize the most efficient providers.

The Administration's plan also calls for the collection of data to develop a reliable case mix adjuster. While clearly necessary, this provision would result in substantial additional costs to agencies. The cost of this new data gathering requirement should be fully reflected in reimbursement rates under this system.

The Administration's PPS plan has serious flaws, as well. Under this plan, the prospective payment system is to be devised by the Secretary without Congressional oversight or participation by industry or consumer groups. The Administration would also reduce home health cost limits and per-beneficiary limits by 15%, prior to implementation of PPS. This reduction is onerous and unnecessary under PPS.

Interim Payment for Home Health Services

This provision delays updates in the Medicare cost limits from July 1, 1997, to October 1, 1997. As of October 1, 1997, the cost limits would be calculated on the basis of 105% of the median of the labor-related and nonlabor per-visit cost for freestanding home health agencies. Currently, cost limits are calculated on the basis of 112% of the mean. The standard of 105% of median is the effective equivalent of approximately 97% of the mean.

A reduction of the cost limits to 105% of the median is estimated to affect the limits by approximately $10.00 per visit for skilled services and nearly $5.00 per visit for home health aide services. This amendment combined with the disregard of two years of cost increases under the section that maintains the savings from the freeze (discussed below), would reduce the cost limits by approximately 17%.

The delay in cost limit updates could provide a benefit to providers of services having cost reporting periods beginning between July 1 and September 30. These providers would maintain the same higher level of cost limits than would be calculated under the revision for a period of two years, while providers of services with fiscal years beginning on or after October 1 would be subject to a precipitous drop in allowable reimbursement.

The savings resulting from the freeze and the interim payment system would be unnecessary if the industry's Revised Unified Plan for Prospective Payment were adopted by the Congress. While the industry's plan would reduce per-visit payment, it gives providers a more important incentive to reduce overall case costs by restraining the growth in the utilization of services per patient.

PPS would achieve reasonable payment reform and associated budget savings without dramatic reductions in the unit of payment. With the current high degree of federal regulation of home health services, it is difficult and sometimes impossible for a home health agency to initiate large cost reductions with little or no notice. The proposed cost limit reductions ultimately carry the risk that

quality of care and access to services may be jeopardized.

Maintaining Savings Resulting From Temporary Freeze on Payment Increases for Home Health Services

This provision in the President's package requires the Secretary to disregard increases in the cost of providing home health care which occurred between July 1, 1994, and July 1, 1996, in updating the home health cost limits after September 30, 1997. The purpose of this provision is to recapture the savings which the program would have incurred if the two-year freeze, which was lifted on July 1, 1996, had been continued. The proposal also limits the Secretary's authority to consider cost changes during the two year period when determining whether a home health agency is entitled to an exemption or exception from the cost limits.

This provision would significantly reduce the current Medicare cost limits. Those limits, implemented with cost report years beginning July 1, 1996, represented the first increase in the limits for home health agencies since July 1, 1993. The reduction in the cost limits through this provision would approximate $7.00 per visit or 7% of the limits. As a result, a significant percentage of home health agencies would provide services at costs above the limit, receiving less reimbursement than the cost of providing the care.

As mentioned earlier, the impact of this provision is magnified when combined with other sections in the President's budget proposal, including the section on interim payment methodology, which further reduce the cost limits for all home health agencies.

Clarification of Part-time or Intermittent Nursing Care

This amendment modifies two provisions of Medicare law which affect the eligibility of beneficiaries for home health services coverage and the level of coverage available. With respect to the test to qualify for home health services coverage, current law requires that the Medicare beneficiary demonstrate a need for skilled nursing care on an intermittent basis or physical or speech therapy.

The provision would restrict Medicare home health eligibility and coverage beyond that available under current law. The existing interpretation of "part-time or intermittent" is the result of a 1988 class action lawsuit which invalidated restrictions on daily, part-time care.

The President's proposal defines "intermittent" as skilled nursing care that is either provided or needed on fewer than seven days each week or less than eight hours of each day of skilled nursing and home health services combined for periods of 21 days or less with certain exceptions. At present, there is no definition of "intermittent" contained within existing statute or regulations.

With respect to the level of coverage available for a qualified Medicare beneficiary, current law limits coverage of skilled nursing care and home health aide services to care which is "part-time or intermittent." This amendment proposes to define "part-time or intermittent" services as a combination of skilled nursing and home health aide services furnished less than eight hours each day

and 35 or fewer hours per week. There is no existing statutory or regulatory definition of this term.

The proposed definition of "part-time or intermittent services" eliminates an important protection which allows for coverage beyond 35 hours per week under exceptional circumstances when the need for the additional care is finite and predictable. This component of the definition allows for short term extended hour coverage for individuals such as those awaiting placement in a skilled nursing facility where no bed was available and those patients with a short term acute episode of care which could be reasonably provided at home, avoiding institutional placement in a hospital or nursing facility.

The proposed definition of "intermittent" used to qualify a Medicare patient for home health services also adds new restrictions. While existing law requires the patient demonstrate a need for intermittent skilled nursing care, the proposed definition of "intermittent" combines skilled nursing and other home health services in determining whether the "intermittent" skilled nursing care requirement has been met. This would exclude eligibility for some patients who currently qualify for Medicare home health services coverage.

For example, an individual that receives daily home health aide services from unpaid caregivers, such as family members, while receiving Medicare covered weekly skilled nursing care would be entirely disqualified from Medicare coverage. Even if this definition were limited to the combination of skilled nursing and other home health services provided by a home health agency, currently eligible Medicare beneficiaries would be denied coverage.

To amend the Medicare act as proposed would not result in a clarification of these terms. Instead, it would result in a reduction in benefits to Medicare beneficiaries.

Definition of Homebound

This amendment establishes new criteria for determining whether an individual's absences from the home demonstrate that the Medicare beneficiary fails to meet the "confined to home" standard. Specifically, the proposal requires that an individual demonstrate the existence of a condition that restricts the ability to leave the home for more than an average of 16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home.

The proposal further defines existing terms of "infrequent" to mean an average of five or fewer absences per calendar month and "short duration" to mean absences of three or fewer hours on average per absence. Current law allows for nonmedical absences which are infrequent or of short duration. Medically related absences for treatment that cannot be furnished in the home do not affect an individual's homebound status.

This proposal would add to the confusion surrounding application of the homebound criteria. Under the proposal, several plausible interpretations may be possible. For example, while the existing law

allows for absences which are either infrequent or of short duration, the proposal referencing absences averaging 16 hours per month may be interpreted to combine these two limitations. At the same time, the 16 hour reference may be interpreted in a manner which indicates that the restrictions for leaving the home begin only after that number of hours since the word "restricts" is not the equivalent of "prevents."

Home care agencies and patients are likely to have great difficulty in dealing with the allowance for medical absences in demonstrating that the treatment "cannot be furnished in the home." Currently, for example, most medically related treatments can be provided in the home. A home visit by a treating physician can often adequately meet a patients needs. However, physician services are not generally accessible in the home.

Many current Medicare beneficiaries, especially disabled patients, may be disqualified from Medicare home health services coverage under this provision. In addition, rather than adding clarity to a confusing area, it only adds to the difficulty in interpretation and application through the addition of new terms subject to dispute.

Individuals that attend adult day care, at no expense to the Medicare program, through the use of specialized transportation should not be disqualified because absences are more frequent than five per calendar month or three hours per absence. These individuals generally cannot receive the necessary health care services outside the home and are truly homebound in the absence in the specialized transportation. Likewise, disabled individuals who are bedbound without the assistance of home health staff should not be disqualified where specialized equipment allow these individuals to leave the home for education, employment, or other purposes. Disqualifying these individuals due to their absences eliminates the availability of essential services which create the opportunity for absences. Many disabled individuals are bedbound unless home health services are provided.

Normative Standards for Home Health Claims Denials

This provision provides authority to the Secretary to deny the frequency and duration of home health services where that care is "in excess of such normative guidelines as the Secretary shall by regulation establish." This provision allows the Medicare program to utilize norms of care for eliminating coverage to individuals.

The Medicare program's practice of using norms of care was outlawed under a settlement agreement in the national class action Duggan v. Bowen in 1989. Under that settlement, the Medicare program is required to render individualized claim determinations which respect to a particular Medicare beneficiary's illness, condition, and need for treatment. At that time, it was recognized by the Medicare program that the determination as to the level of care which was reasonable and necessary could only be rendered through an individualized review of that patient's circumstances.

This provision should be rejected. The federal government should not attempt to micro manage how much and what types of home care services each patient can receive. PPS for home care would provide prudent payment levels while allowing home health care providers to determine how best and

most efficiently to meet patients' needs. A similar approach is used with Medicare hospital services under which a flat payment is made to a facility based upon a patient's diagnosis regardless of whether the patient receives care less than or in excess of the norms. The hospital payment provision, however, provides for an outlier payment to recognize that certain patients reasonably require care beyond normative standards.

Further, the Secretary cannot reasonably and accurately establish normative guidelines for home care. Currently, the Medicare program is developing a case mix adjuster for use in a future PPS. However, that case mix adjuster, while categorizing patients, is expected to allow for flexibility in the provision of services to patients within the respective categories.

The use of norms implies an average amount of care for patients within set criteria. Averages cannot be used to deny coverage to individuals since the averages are made up of a range of care needs of specific patients. This proposal will guarantee that many individuals who need home health services would be denied Medicare coverage.

The implementation of this provision will also lead to an endless series of disputes, including litigation, as to the accuracy and objectivity of the calculated norm of care for the particular category of patient. In the end, this provision will be costly to administer, creating harm to Medicare beneficiaries, leading to increased health care costs for underserved patients, and restricting coverage to individuals currently entitled under Medicare law.

Development and Implementation of Integrated Payment System for Post Acute Services

This provision authorizes the Secretary to establish an integrated payment system for post acute services furnished by skilled nursing facilities, home health agencies, rehabilitation hospitals, long term care hospitals or such other entities as the Secretary deems appropriate. The payment system may include a single prospective pay rate for all services or a limit on the amounts payable to individual providers or to a single entity.

In establishing the payment system, the Secretary must consider equitable payments across provider types, case mix adjustments, geographic variation, and outlier payments. The Secretary must establish the system to be budget neutral. The system must include quality assurance and monitor. Finally, the Secretary is authorized to require providers of services to supply the necessary data and other information necessary for implementation, including the development of a standardized core patient assessment instrument.

The authority of the Secretary to implement an integrated payment system for post acute services does not apply to payments for services furnished before 2002.

NAHC opposes combining, or bundling, home care payments with payments to other providers. Congress should, instead, enact separate prospective payment systems for home care and other post-acute care providers.

Congress should also rebase the hospital DRGs to reflect shorter lengths of stay that have occurred under the hospital PPS.

Nearly half (41%) of all home care patients are now able to receive care and treatment at home from the onset of their illness, avoiding hospitalizations altogether. According to the Prospective Payment Assessment Commission's (ProPAC) June 1996 report to Congress, patients in other post-acute settings were usually discharged from acute care hospitals, but only 59% of all home health episodes were preceded by a Medicare-covered hospital stay.

Bundling would vastly increase Medicare's administrative complexity and the cost of providing home care services by requiring multiple payment systems for home care -- one for post-acute patients and one for other home care patients.

User Fees

The Administration would allow States to impose user fees on providers for initial surveys needed for participation in the Medicare program. NAHC opposes user fees and recommends that Congress ensure sufficient funds to cover the costs for survey and certification activities without imposing additional fees on providers.

For the past several years, HCFA's funding for survey and certification activities has been insufficient to complete the level of reviews mandated by Congress. As a result, many state survey agencies were unable to conduct initial surveys of new providers in a timely manner. Providers in these states, therefore, are experiencing long delays in receiving Medicare certification.

The fiscal year 1996 budget (P.L. 104-134) contained a provision designed to provide HCFA the budget flexibility to begin to alleviate the backlog of initial certifications. The legislation increased the time between home health recertifications from once every 12 months to once every 36 months and expanded HCFA's authority to deem agencies as certified if the agencies are accredited by certain private accrediting bodies. In addition, Congress appropriated an additional $10 million over FY96 levels for survey and certification activities in FY97.

Despite these legislative efforts, backlogs for initial surveys in some states still exist. The Administration's proposal would allow states to impose user fees on providers for their initial surveys. In addition, the President's budget reduces the direct appropriation request for survey and certification by $10 million. The Administration estimates that this $10 million reduction will be made up from user fees, thereby keeping the funding for survey and certification activities at FY97 levels.

User fees are a tax on new providers for participating in the Medicare program. Asking health care providers to provide quality care while at the same time asking them to shoulder both government costs and their own expenses related to the Medicare program is unfair. Moreover, while the proposal imposes user fees only on initial surveys, some existing providers may also be subject to this "tax." For example, home health agencies who wish to open a hospice would be subject to the fee for the hospice's initial survey. In addition, HCFA's recent reclassification of some home health

branch offices as subunits would also require initial surveys be conducted for those reclassified facilities.

Fraud and Abuse

NAHC opposes repeal of important provider guidance provisions contained in the Health Insurance Portability and Accountability Act (P.L. 104-191).

The Health Insurance Portability and Affordability Act of 1996 (HIPAA) put in place a broad based anti-fraud package that balances increased enforcement tools with opportunities for provider guidance. The fraud and abuse legislation established a criminal health fraud statute and increased civil monetary penalties. At the same time, the legislation clarified existing law, created a safe harbor exception for certain risk-sharing arrangements and allowed providers to request advisory opinions from the Department of Health and Human Services (HHS).

The President's budget proposal calls for the repeal of advisory opinions, the exception to anti-kickback penalties for risk-sharing arrangements, and the clarification concerning levels of knowledge required for imposition of civil monetary penalties.

HIPAA reflected an effort to balance increased enforcement tools with greater opportunities for guidance and clarification of areas that have previously led to confusion and unintended consequences for providers. Provisions such as the establishment of advisory opinions will assist home care and hospice providers in ensuring that they remain in compliance with health care statutes and regulations. Without these provisions, new criminal sanctions and increased civil monetary penalties may be imposed on home health and hospice providers without adequate opportunities for guidance or clarification of existing law.

Site of Service

The intent of this section in the President's proposal is to ensure that Medicare payments for home care more closely reflect the costs of care in the place where the care is given, the patient's home, rather than the site of the home health agency office.

This section would address this issue by requiring that home health agencies submit claims for payment for home health services on the basis of the geographic location at which the service is furnished. Labor costs associated with the area in which each patient receives home care, rather than the agency office, would be used in calculating Medicare payment limits for home care services.

NAHC supports this section, with two significant changes.

First, the section should be rewritten to clarify its intent and to amend Section 1815, rather than Section 1891, of the Social Security Act.

Section 1891 of the Social Security Act sets out requirements to assure home health quality, such as patient rights, training and competency testing of home health aides, and quality surveys and sanctions for home health agencies found to be out of compliance with the quality measures of Section 1891.

The President's proposal would require quality surveyors to begin examining claims forms to find that they match with the correct FI for each patient's area. Quality surveyors are already sorely overworked and underfunded. This non-quality specific requirement would detract from their ability to devote their efforts to ensuring high quality standards in all home health agencies.

This section should be moved to Section 1815 of the Social Security Act, which sets out requirements that providers must meet in order to receive payments under the Medicare program. In order to avoid adding new administrative costs and complexity, the provision should make clear that the fiscal intermediary in the area where the agency, rather than the patient, is located would handle the claims.

Second, home care payments should reflect the labor costs for activities performed both in the patient's location and in the home office area. The Administration's proposal would only recognize the varying labor costs that occur specific to the site of care. Billings, clerk functions, and other activities that are carried out in the agency office should reflect the costs of labor in the office location.

Respite

The President's budget proposal would establish a new respite benefit for the families of Medicare beneficiaries with Alzheimer's disease or other irreversible dementias, beginning in FY98. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the Secretary of HHS.

Payments would be made at a rate of $7.50 per hour for 1998 and at a rate to be determined by the Secretary in subsequent years. Total payment to the agency or organization furnishing respite services could not exceed 110 percent of the hourly respite allowance times the number of hours of respite for which the agency authorizes payment.

Beneficiaries eligible for this benefit must be severely impaired due to irreversible dementia and need assistance in at least one of five activities of daily living (bathing, dressing, transferring, toileting and eating) or in at least one out of four instrumental activities of daily living (meal preparation, medication management, money management, and telephoning), or needs constant supervision because of a behavioral problem.

Families would be allowed to designate a respite services caregiver through a home health agency or other organization designated by the Secretary. The patient could not be charged more than $2.00 in excess of the the hourly rates established by the legislation.

Respite aides may be nurse aides, home health aides, or other individuals licensed by the State or recognized by the Secretary as having the skills necessary to provide such services.

NAHC is pleased that the Administration has proposed a modest beginning in addressing this unmet need. Nearly three-quarters of non-institutionalized disabled elderly persons rely solely on care by friends and family; only 5% receive all of their care from paid sources.

While the respite provision is a step in the right direction, it provides for too few hours and the rates of reimbursement are inadequately low. Payment rates should reflect variation in costs by geographic region and should be adequate to both attract qualified respite aides and pay for their training and supervision. The legislation should also mandate that the Secretary develop competency standards for respite aides.

The availability of respite care can mean the difference between continuation of in-home care and institutionalization. Experience with the implementation of even a small scale respite benefit can provide critical information about issues such as administration, appropriate eligibility criteria and quality assurance. This information will be essential to the future development of a more comprehensive benefit.

Ultimately, Congress should include in-home respite care in the Medicare home health benefit. Eligibility should be based on a broader definition of functional and cognitive impairments.

Elimination of Periodic Interim Payments for Home Health Agencies

This proposal eliminates the availability of a longstanding method of payment for home health agencies known as Periodic Interim Payments (PIP), effective with the initiation of a proposed prospective payment system (PPS) on October 1, 1999.

PIP is a system which projects an agency's expected Medicare home health payments and provides biweekly reimbursement to the agency based upon that projection. Under PIP, adjustments for underpayments and overpayments are made throughout the fiscal year in order to achieve reimbursement consistent with total amount owed by the end of the fiscal year.

Periodic Interim Payments have been essential for many home health agencies in order to maintain an appropriate cash flow to meet the labor-intensive cost of delivering home health services. Unlike many other health care providers, such as hospitals and nursing facilities, home health agencies do not have ready access to capital or credit due to a lack of profits through cost reimbursement and limited capital equity. PIP has helped providers avoid interest costs and revenue shortfalls which could jeopardize the continued delivery of services to patients.

The industry has expressed a willingness to accept the elimination of PIP corresponding with the implementation of the industry's PPS plan. The Administration's proposal however, while eliminating PIP at the implementation of PPS, does not provide the type of interim PPS system proposed by the industry which would allow for home health agencies to build capital pending the transition to PPS. NAHC recommends that PIP, in this case, be eliminated twelve months after the implementation of episodic PPS.

Payment Under Part B

This section amends Section 1833(a)(2) of the Social Security Act, conforming payments for Medicare Part B home health services to the amended cost limit provision and interim payment methodology set out in the President's package. In addition, it has the effect of eliminating the lower of cost or charges principle from the determination of rates of payment. Currently, Medicare limits reimbursement to home health agencies based on the lower of its costs or charges. This proposal will continue an exemption from the lower cost or charges principle for certain public providers that offer services at a nominal charge.

While the provision appropriately modifies Part B payment structures to conform with the overall payment reform measures affecting home health services under Medicare, it may have inadvertently eliminated application of the lower of cost or charges principle. The NAHC supports the elimination of the lower cost or charges rule (LCC). However here, the proposed action eliminates LCC only for Part B and not for Part A.

V. OTHER ISSUES OF IMPORTANCE TO HOME CARE

Waiver of Liability

Also included in the BBA and closely linked to enactment of PPS was a provision to extend the presumptive status of the waiver of liability for home care, a provision of great importance to NAHC.

In 1972 the Health Care Financing Administration created a presumptive waiver of liability status for Medicare providers. Under the presumptive waiver, providers were presumed to have acted in good faith and were paid for services to a Medicare patient if their low error rate demonstrated a reasonable knowledge of coverage standards in their submission of bills. The presumptive waiver was later incorporated into legislation which after several extensions expired for home care and hospice on December 31, 1995.

The BBA would have extended the presumptive waiver for home care until October 1, 1996, when the Act provided that a prospective payment system would be established for home care. When the Act was vetoed, the presumptive status of the waiver expired.

To make matters worse, HCFA has imposed a system which presumes fraud by assuming providers knew their claims would not be covered, forcing providers to appeal each claim. Reconsideration of claims costs the federal government approximately $400 per claim, and costs providers in the range of $150 for each claim, just to reach the point of requesting waiver protection. If the dispute moves to the Administrative Law Judge level, the federal government and the provider each incur likely costs of $1,000 per claim reviewed.

In order for a home care agency to be compensated under the waiver presumption, its overall denial of claims rate had to be less than 2.5% of the Medicare services provided. Any agency that exceeded this limit was not reimbursed under the presumptive waiver. This requirement forced agencies to use due diligence in determining eligibility and coverage.

Given the vague application of constantly changing regulations, guidelines, and directives, it is difficult enough for home health agencies to be 97.5% correct in their determinations of eligibility. The high number of claims denials that are reversed (25% at reconsideration stage and 70% at the Administrative Law Judge level) shows that coverage decisions are not as clear cut as HCFA asserts. At a time when sicker patients are admitted to home care following earlier hospital discharges, coverage questions are more complex, and the buffer zone of the waiver presumption is particularly important.

Congress enacted the presumptive waiver to encourage home health agencies to provide services to Medicare patients, and to save on the considerable administrative time and expense of handling appeals in cases where agencies are delivering services in the good faith belief that the services are covered by Medicare. In the absence of the waiver presumption, agencies will have no recourse but to reject clients if there are any doubts about coverage. The waiver presumption for home health agencies and hospices should be permanently reinstated and made retroactive to January 1, 1996.

Copays

We are pleased that the President's FY98 budget proposal does not include the imposition of copayments on Medicare home health services. Imposition of a home health copayment would create a new "sick" tax on the most frail and vulnerable elderly and disabled Americans -- those who could least likely afford it. Moreover, the policy is "penny wise and pound foolish" and may end up costing the Medicare program more since patients who cannot afford the copayment may defer necessary services, resulting in subsequent nursing home placements, hospitalization or care from other more costly institutions.

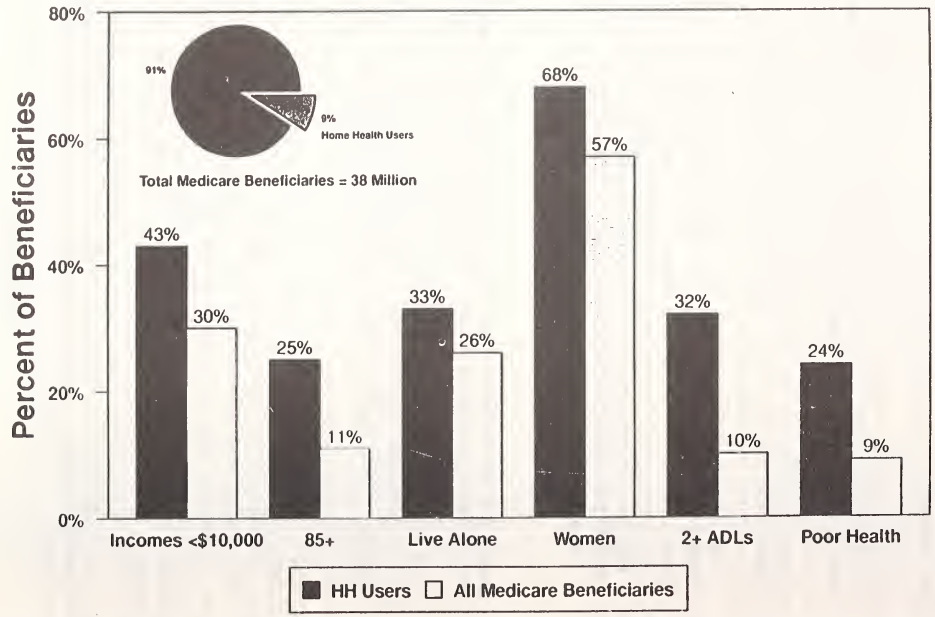
Medicare home health copayments do not take into account the in-kind contributions made by Medicare home care patients toward the cost of their care. When Medicare pays for the care of an individual in a nursing home or hospital, it also pays its share of the cost of the building, maintenance, overhead, food, heat, and other significant costs, none of which Medicare incurs with home care. In addition, home care patients, families, and friends make significant contributions to care through "sweat equity." Individuals who receive no Medicare reimbursement provide significant care to Medicare home care patients, as home care nurses train family members and friends to provide care at home.

When the home health benefit was first enacted in 1965, it contained a copayment requirement. This copayment was later dropped because it cost Medicare more to collect in administrative costs than it saved the program. Copayments were a bad idea then, they are a bad idea now.

CONCLUSION

Thank you again, Mr. Chairman, for the opportunity to present our views. Home care has waited for many years to get to this point in the development and consideration of a prospective payment system for home care. You and the Committee have our thanks for bringing the issue to this level of consideration and we look forward to working closely with you in bringing PPS to enactment and on the other important issues facing home care this year.

Characteristics of Medicare Home Health Users



Source: HCFA, 1994 Medicare Current Beneficiary Survey

Declaration of Support for Implementation of a Prospective Payment System for Medicare Home Health Services

SEPTEMBER 25, 1996

Whereas the health care industry is facing rapid and significant changes both in the delivery of services and its relationships with payors;

Whereas the health care delivery system is increasingly relying on some form of managed care to encourage providers to achieve patient centered, favorable outcomes in the most cost effective manner possible;

Whereas the current structure of cost reimbursement for Medicare home health services is counterproductive to the goals of delivering high quality, cost effective, and medically necessary services;

Whereas the home health industry must move to a prospective payment system to operate more consistently with non-Medicare reimbursement systems;

Whereas the Congress and the Administration have indicated that the rate of expenditure growth in the Medicare home health benefit, combined with the overall financial state of the Medicare program, requires the adoption of some measure to reduce the growth rate in Medicare home health expenditures per patient in future years;

Whereas the home health industry considers copayments, at any level, an unacceptable and improper burden on the infirm, elderly, and disabled who receive Medicare home health services given the significant contributions made by these individuals and their families as primary caregivers in the home setting;

Whereas the home health industry considers proposals to "bundle" home health payment with other Medicare payments, such as hospital services, to be inappropriate and counterproductive in achieving the goal of providing care in the most cost effective setting possible;

Whereas the Congress has requested the home health industry to offer a substitute for copayments and bundling that provides incentives for reducing the rate of expenditure growth while preserving access to medically necessary home health services;

Whereas the home health industry considers the implementation of a prospective payment system to be the appropriate mechanism to address the needs and concerns of patients, the Medicare program, and the home health industry;

Be It Resolved that the following organizations, comprised of the National and State Associations representing the interests of Medicare certified home health agencies, and the patients they serve, nationwide commit their support for the enactment and implementation of a prospective payment system which is entitled "The Revised Unified Plan", as attached hereto.

Signed,

HOME HEALTH SERVICES AND STAFFING ASSOCIATION • NATIONAL ASSOCIATION FOR HOME CARE • VISITING NURSE ASSOCIATION OF AMERICA

Revised Unified Proposal for a
Prospective Payment System for Medicare Home Health Services

March 28, 1996

Attached is the Industry's Unified Plan for Prospective Payment System (PPS) for Medicare Home Health Services. It was developed jointly by the National Association for Home Care (NAHC) and the PPS Work Group.

This plan is a modification of the original unified plan submitted to Congress in 1995 as an alternative to Congressional movement to impose copays on Medicare home care services or to bundle home care payments into payments to hospitals. The modifications were made to the original proposal to respond to concerns about implementation feasibility raised by HCFA.

This plan incorporates the best elements of the home care PPS provisions in HR 2491 passed by Congress and HR 2530. It represents months of work and refinement by the home care industry. The plan calls for a three–phase approach to achieving episodic PPS. It starts with an interim PPS plan that utilizes existing data and processes and moves to an episodic PPS with a refined case mix adjuster.

PPS is a more efficient, cost–effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety, or increasing out–of–pocket costs.

We invite your careful review of this proposal. If you have any questions or would like additional information please feel free to contact any of our organizations at the numbers listed below.

National Association for Home Care
Dayle Berke/Lucia DiVenere 202–547–7424

PPS Work Group
Jim Pyles 202–466–6550

3–28–96

Home Care's Plan to Implement Prospective Payment for Medicare Home Health Services

I. Home Care's Goal

The goal of the home care provider community is to manage the growth of Medicare home health expenditures in a manner that promotes efficiency and preserves access to quality care for Medicare beneficiaries. This will be accomplished through the development and implementation of an episodic prospective payment system as soon as feasible. PPS is a more efficient, cost–effective alternative for achieving reductions in the growth of expenditures than copays or bundling of home care services. PPS can accomplish this goal without jeopardizing beneficiary health and safety.

PPS will be phased in over time, culminating in an episodic prospective payment system plan that should:

- o be developed cooperatively by HHS, the industry, and Congress
- o be acceptable to the industry
- o include extended care
- o be submitted to Congress one year in advance of implementation, and within 4 years of enactment of legislation
- o be approved by Congress
- o include adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o be based on a case mix adjustor that reflects the differences in cost for different types of patients

II. An Interim PPS Plan

An interim PPS plan incorporating certain elements of the Congressional and Democratic proposals (HR 2491 and HR 2530) should be implemented commencing within 6 months of enactment and continue until it can be converted to a pure episodic prospective payment system (Phase III). The interim PPS plan should be based on the industry's design and set forth in legislative language. The interim plan is implemented in phases to provide HCFA sufficient time to collect necessary data and to develop required processes and procedures. Current coverage criteria for Medicare home health services should be maintained and no coverage shifted to Part B.

III. Time Line for PPS Phase-In

Enact Legis.	Begin Data Collec	Begin Phase I Interim PPS	Begin Phase II Interim PPS	Report to Congress on Episodic PPS	Expected Implementation Phase III Episodic PPS
0	2mo	6mo	24mo –30mo	48mo	60mo

IV. PPS SPECIFICATIONS

A. Data Collection

HCFA is mandated to begin immediately to develop a data base upon which a fair and accurate case mix adjustor can be developed and implemented. The data base must be able to link case mix data with cost (and utilization) data.

The data base must include a sample sufficiently large to support the development of statistically valid estimates of payment rates and limits for the geographic area used (e.g., MSA/nonMSA, national, census region).

The data base must contain at least:

- items for the 18 category Phase II case mix adjustor
- HCFA form 485
- UB–92
- additional data items that may contribute to a more accurate case mix system, developed with industry participation (such as items from OASIS)

Payment rates and limits shall be adjusted to reflect cost of data collection

Effective date: 60 days after enactment

B. Phase-In of PPS Beginning with the Interim Plan

Phase I

Prospectively set standard per visit payment (as in HR 2491) with an annual aggregate per patient limit that applies to all visits (as in HR 2530)

Effective date: 6 months after enactment

All currently allowable costs related to nonroutine medical supplies will be included in the data base for calculating the per visit rate, per visit limit, and aggregate limits.

Per visit payment

- o standard per visit rate for each discipline calculated (as in HR 2491) as follows:

  the national average amount paid per visit under Medicare to home health agencies for each discipline during the most recent 12 month cost reporting period ending on or before 12–31–94 and updated by the home health market basket index, except that the labor–related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located

- o amounts in excess of the per visit rate, up to a limit as defined below, may be paid if:
  1) an HHA can demonstrate costs above the payment rate, and
  2) quarterly reports demonstrate that total payments will not exceed the agency aggregate limit

- o the payment rates and limits are calculated initially from the base year costs and cost limits and updated by the home health market basket index to the date of implementation; they are updated annually by the market basket index

- o base year for payment rates and cost limits – 1994 (using settled cost reports)

Agency annual aggregate per patient payment limit

- o base year for aggregate payment limit – 1995 utilization data for each agency

- o the blended annual per patient limit is based on the reasonable cost per unduplicated patient in the base year (1994 cost per visit–updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 75% on agency data & 25% on census region data for 12 months following implementation of Phase I, then 50% agency data & 50% census region data

- o the blended annual aggregate per patient limit is equal to the number of unduplicated patients served in the year multiplied by the per patient blended limit

- o census region: the 9 census region geographic areas (New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, Pacific)

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate per patient cap and below 125% of the census region cost/utilization experience shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limit. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

- o Phase I in place 18 months (no longer than 24 months)

Phase II

Prospectively set standard per visit payment with an annual aggregate episode limit for days 1–120 (as in HR 2491); and an annual aggregate per patient limit for visits after 120 days

- o continue per visit payment as in Phase I
- o an episode is 120 days; post 120 day care is paid per visit with an annual aggregate per patient blended limit for the post 120 day period that is separate from the 1–120 day annual aggregate episode limit
- o the HHA is credited for a new episode limit if there is a period of 45 days without Medicare covered home health care services following the 120 day episode (if a patient is readmitted before a new episode can be started, the agency is paid per visit subject to the aggregate episode limit if within the first 120 days, or the separate post 120 day aggregate per patient blended limit if after 120 days)
- o the 18 category Phase II case mix adjustor is applied to the first 120 days, or a more accurate one if available
- o the per episode limit (as in HR 2491) is equal to the mean number of visits for each discipline during the 120 day episode of a case mix category in an area during the base year multiplied by the per visit payment rate for each discipline
- o the annual aggregate episode limit (as in HR 2491) is equal to the number of episodes of each case mix category during the fiscal year multiplied by the per episode limit determined for such case mix category for such fiscal year
- o the region for the episode limit – MSA/nonMSA area
- o the annual post 120 day per patient blended limit is based on the reasonable cost per unduplicated patient receiving care beyond 120 days in the base year (1994 cost per visit–updated, multiplied by 1995 utilization) and updated by the home health market basket index; calculation based 50% on agency data & 50% on census region data
- o the annual aggregate post 120 day per patient blended limit is equal to the number of unduplicated patients receiving care beyond 120 days in the year multiplied by the per patient blended limit
- o the current certification and coverage guidelines continue

Sharing Savings

HHAs that are able to keep their total payments for the year below their annual aggregate episode and post 120 day per patient caps; and the post 120 day per patient payments below 125% of the census region cost/utilization experience, shall receive a payment equal to 50% of the difference between the total per visit payments and the agency's aggregate limits. Such payments may not exceed 10% of an agency's aggregate Medicare per visit payments in a year.

Phase III (as noted under the goal in section I)

Per Episode PPS

- o developed cooperatively by HHS, the industry, and Congress
- o acceptable to the industry
- o includes extended care
- o must be submitted to Congress one year in advance of implementation and within 4 years of enactment of legislation
- o approved by Congress
- o adjustments for new requirements (such as OSHA) or changes in technology or care practices
- o case mix adjustor that reflects the differences in cost for different types of patients

C. Additional Specifications that Apply to All Phases

1. **Exceptions**: The Secretary shall provide for an exemption from, or an exception and adjustment to, the methods for determining payment limits where extraordinary circumstances beyond the home health agency's control including outliers and the case mix of such home health agency, create unintended distortions in care requirements not accounted for in the case mix adjustor payment system. The Secretary shall develop a method for monitoring expenditures for such exceptions. Methods should be developed to allow for additional home care expenditures when they are found to decrease total Medicare expenditures.

2. **Quality**: Any prospective payment system must ensure that home health agencies do not seek to become more cost effective by sacrificing quality. The Secretary will ensure that the quality of services remains high by implementing a revised survey and certification process which emphasizes patient satisfaction and successful outcomes.

   Home health agencies will be required to provide covered services to beneficiaries to the extent that those services are determined by the beneficiary's physician to be medically necessary.

   There will be established a means for beneficiary due process to challenge care and coverage determinations first through internal provider grievance procedures, then through external PRO review.

   There will be established a mechanism for quality review for instances of significant variation in utilization by providers. (this can address both visits and admissions)

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Phase I Example	1
Per Visit Payment (by discipline)	
Set Payment Rate per Visit	$50
Payment Limit per Visit	$55
Cost per Visit	$49
Payment per Visit	$50
Aggregate Limit	
Agency average cost/patient/year	$2,600
Agency average visits/patient/year	53
Average region cost/patient/year	$2,800
Agency per patient limit	$2,650
No. of unduplicated patients	1,000
Agency aggregate limit	$2,650,000
No. of visits made	52,000
No. of visits per patient	52
Total per visit payments	$2,600,000
Savings/(Overpayment)	$50,000
50% of savings	$25,000
10% total payment-maximum	$260,000
Total Cost	$2,548,000
Agency average cost per patient	$2,548
125% of census region avg per patient	$3,500
Bonus payment	$25,000
Total reimbursement (payt-over+bonus)	$2,625,000
Total cost	$2,548,000
Profit (loss)	$77,000

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Phase I Example	1 Average	Decrease cost/visit	Decrease utilization	2 Low visit cost Low utilization	Increase Utilization	3 Low visit cost High Utilization	Decrease utilization	4 High visit cost Low utilization	Decrease visit cost
Per Visit Payment (by discipline)									
Set Payment Rate per Visit	$50	$50	$50	$50	$50	$50	$50	$50	$50
Payment Limit per Visit	$55	$55	$55	$55	$55	$55	$55	$55	$55
Cost per Visit	$50	$49	$50	$48	$48	$47	$50	$57	$56
Payment per Visit	$50	$50	$50	$50	$50	$50	$50	$55	$55
Aggregate Limit									
Agency average cost/patient/year	$2,800	$2,800	$2,800	$2,400	$2,400	$3,290	$3,290	$3,000	$3,000
Agency average visits/patient/year	56			50		70		53	
Average region cost/patient/year	$2,800	$2,800	$2,800	$2,800	$2,800	$2,800	$2,800	$2,800	$2,800
Agency per patient limit	$2,800	$2,800	$2,800	$2,500	$2,500	$3,168	$3,168	$2,950	$2,950
No. of unduplicated patients	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Agency aggregate limit	$2,800,000	$2,800,000	$2,800,000	$2,500,000	$2,500,000	$3,167,500	$3,167,500	$2,950,000	$2,950,000
No. of visits made	56,000	56,000	53,000	50,000	52,000	70,000	60,000	50,000	50,000
No. of visits per patient	56	56	53	50	52	70	60	50	50
Total per visit payments	$2,800,000	$2,800,000	$2,650,000	$2,500,000	$2,600,000	$3,500,000	$3,000,000	$2,750,000	$2,750,000
Savings/(Overpayment)	$0	$0	$150,000	$0	($100,000)	($332,500)	$167,500	$200,000	$200,000
50% of savings	$0	$0	$75,000	$0	$0	$0	$83,750	$100,000	$100,000
10% total payment-maximum	$280,000	$280,000	$265,000	$250,000	$260,000	$350,000	$300,000	$275,000	$275,000
Total Cost	$2,800,000	$2,744,000	$2,650,000	$2,400,000	$2,496,000	$3,290,000	$3,000,000	$2,850,000	$2,800,000
Agency average cost per patient	$2,800	$2,744	$2,650	$2,400	$2,496	$3,290	$3,000	$2,850	$2,800
125% of census region avg per patient	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500
Bonus payment	$0	$0	$75,000	$0	$0	$0	$83,750	$100,000	$100,000
Total reimbursement (payt-over+bonus)	$2,800,000	$2,800,000	$2,725,000	$2,500,000	$2,500,000	$3,167,500	$3,083,750	$2,850,000	$2,850,000
Total cost	$2,800,000	$2,744,000	$2,650,000	$2,400,000	$2,496,000	$3,290,000	$3,000,000	$2,850,000	$2,800,000
Profit (loss)	$0	$56,000	$75,000	$100,000	$4,000	($122,500)	$83,750	$0	$50,000

The agency-specific component captures the differences in case mix across agencies in the base year
Yr 1: 75% agency/25% census region
Yr 2: 50% agency/50% census region

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Phase II Episode Example	1
Per Visit Payment (by discipline)	
Skilled Nursing	
Set Payment Rate per Visit	$100
Payment Limit per Visit	$110
Cost per Visit	$99
Payment per Visit	$100
Aide	
Set Payment Rate per Visit	$50
Payment Limit per Visit	$55
Cost per Visit	$50
Payment per Visit	$50
Episode Limit	
# Episodes (category 1)	1,000
Episode Limit (category 1)	$2,500
Subtotal (category 1)	$2,500,000
# Episodes (category 2)	2,000
Episode Limit (category 2)	$1,500
Subtotal (category 2)	$3,000,000
Agency Aggregate Limit	**$5,500,000**
No. of SN visits made	28,000
Subtotal SN payments	$2,800,000
No. of Aide visits made	50,000
Subtotal Aide payments	$2,500,000
Total per visit payments	$5,300,000
Savings/(Overpayment)	$200,000
50% of savings	$100,000
10% of total payment - maximum	$530,000
Bonus payment	$100,000
Total reimbursement (payt-over+bonus)	$5,400,000
Total cost	$5,272,000
Profit/(Loss)	$128,000

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Phase II Episode Example	1	2 Low visit cost High utilization	3 High visit cost Low utilization
Per Visit Payment (by discipline)			
Skilled Nursing			
Set Payment Rate per Visit	$100	$100	$100
Payment Limit per Visit	$110	$110	$110
Cost per Visit	$99	$90	$112
Payment per Visit	$100	$100	$110
Aide			
Set Payment Rate per Visit	$50	$50	$50
Payment Limit per Visit	$55	$55	$55
Cost per Visit	$50	$45	$58
Payment per Visit	$50	$50	$55
Episode Limit			
# Episodes (category 1)	1,000	2,000	1,000
Episode Limit (category 1)	$2,500	$2,500	$2,500
Subtotal (category 1)	$2,500,000	$5,000,000	$2,500,000
# Episodes (category 2)	2,000	1,000	1,500
Episode Limit (category 2)	$1,500	$1,500	$1,500
Subtotal (category 2)	$3,000,000	$1,500,000	$2,250,000
Agency Aggregate Limit	**$5,500,000**	**$6,500,000**	**$4,750,000**
No. of SN visits made	28,000	30,000	25,000
Subtotal SN payments	$2,800,000	$3,000,000	$2,750,000
No. of Aide visits made	50,000	60,000	40,000
Subtotal Aide payments	$2,500,000	$3,000,000	$2,200,000
Total per visit payments	**$5,300,000**	**$6,000,000**	**$4,950,000**
Savings/(Overpayment)	$200,000	$500,000	($200,000)
50% of savings	$100,000	$250,000	$0
10% of total payment - maximum	$530,000	$600,000	$495,000
Bonus payment	**$100,000**	**$250,000**	**$0**
Total reimbursement (payt-over+bonus)	$5,400,000	$6,250,000	$4,750,000
Total cost	$5,272,000	$5,400,000	$5,120,000
Profit/(Loss)	$128,000	$850,000	($370,000)

EXHIBIT 1: NATIONAL HOME HEALTH AGENCY PROSPECTIVE PAYMENT DEMONSTRATION
Patient Classification System for Casemix Adjustment

ADMISSION CHARACTERISTICS *(from Base Year Admission Form)*

Hospital stay during 120 days? *(from HCFA claims data)*	ADL limitations (of 5)	Need wound care?	Pre-admission location = hospital?	Decubitus stage 3 or 4?	Diabetes?	CVA?	Cancer?	CASEMIX GROUP:
YES	0-3	YES	YES	>>>>>	>>>>>	>>>>	>>>>>	= 1
YES	0-3	YES	NO	>>>>>	>>>>>	>>>>	>>>>>	= 2
YES	0-3	NO	YES	>>>>>	>>>>>	>>>>	>>>>>	= 3
YES	0-3	NO	NO	>>>>>	>>>>>	>>>>	>>>>>	= 4
YES	4-5	YES	>>>>>	YES	>>>>>	>>>>	>>>>>	= 5
YES	4-5	YES	>>>>>	NO	>>>>>	>>>>	>>>>>	= 6
YES	4-5	NO	>>>>>	>>>>>	>>>>>	YES	>>>>>	= 7
YES	4-5	NO	>>>>>	>>>>>	>>>>>	NO	YES	= 8
YES	4-5	NO	>>>>>	>>>>>	>>>>>	NO	NO	= 9
NO	0-1	YES	YES	>>>>>	>>>>>	>>>>	>>>>>	= 10
NO	0-1	YES	NO	>>>>>	>>>>>	>>>>	>>>>>	= 11
NO	0-1	NO	>>>>>	>>>>>	YES	>>>>	>>>>>	= 12
NO	0-1	NO	>>>>>	>>>>>	NO	>>>>	>>>>>	= 13
NO	2-5	YES	>>>>>	YES	>>>>>	>>>>	>>>>>	= 14
NO	2-5	YES	>>>>>	NO	>>>>>	>>>>	>>>>>	= 15
NO	2-5	NO	>>>>>	>>>>>	YES	>>>>	>>>>>	= 16
NO	2-5	NO	>>>>>	>>>>>	NO	YES	>>>>>	= 17
NO	2-5	NO	>>>>>	>>>>>	NO	NO	>>>>>	= 18

NOTES:

- The weight for each group is determined by each agency's historical pattern (number and type of visits) of caring for patients in the group. The weight for a given group may differ significantly from agency to agency.
- These groups are used only to adjust for changes in an agency's casemix from year to year, which are expected to be minor. They are NOT intended to adjust for differences across agencies, which can be major.
- Cross-agency differences are controlled for by setting agency-specific payment rates, based on each agency's historical costs and episode service pattern.

For more information about the National Home Health Agency Prospective Payment Demonstration, contact Henry Goldberg, 617-349-2482

PREPARED STATEMENT OF WILLIAM J. SCANLON

Mr. Chairman and Members of the Committee: We are pleased to be here today to discuss Medicare's skilled nursing facility (SNF), home health care, and inpatient rehabilitation benefits and the administration's forthcoming legislative proposals related to them. After relatively modest growth during the 1980s, Medicare's expenditures for SNFs and home health care have grown rapidly in the 1990s. Expenditures for inpatient rehabilitation facilities have grown rapidly since the mid-1980s. SNF payments rose from $2.8 billion in 1989 to $11.3 billion in 1996, while home health care costs grew from $2.4 billion to $17.7 billion over the same period. Rehabilitation facility payments increased from $1.4 billion in 1989 to $3.9 billion in 1994.[1] Over those periods, annual growth averaged 22 percent for SNFs, 33 percent for home health care, and 23 percent for rehabilitation facilities.

My comments today will focus on the reasons for cost growth and the administration's announced legislative proposals for these three Medicare benefits. The information presented today is based on our previous work and the most recent data on the benefits available from the Health Care Financing Administration (HCFA), which manages Medicare. Because the legislative proposals were only recently released by the administration, our analysis was primarily based on summaries of them that were publicly released earlier in the year and our discussions with HCFA officials about the proposals.

In brief, Medicare's SNF costs have grown primarily because a larger portion of beneficiaries use SNFs than in the past and because of a large increase in the provision of ancillary services. For home health care costs, both the number of beneficiaries and the number of services used by each beneficiary have more than doubled. Although the average length of stay has decreased for inpatient rehabilitation facilities, a larger portion of Medicare beneficiaries use them now, which results in cost growth. A combination of factors led to the increased use of these benefits:legislation and coverage policy changes in response to court decisions liberalized coverage criteria for the SNF and home health benefits, enabling more beneficiaries to qualify for them;

— these changes also transformed the nature of home health care from primarily post-hospital care to more long-term care for chronic conditions;
— earlier discharges from hospitals led to the substitution of days spent in SNFs for what in the past would have been the last few days of hospital care;
— use of ancillary services, such as physical therapy, in SNFs has increased, and specific controls for these services have not been implemented;
— rapid growth in the number of inpatient rehabilitation beds available and use of these beds by beneficiaries, as well as the likelihood of some substitution of rehabilitation days for general hospital days, led to higher expenditures for inpatient rehabilitation; and
— a diminution of administrative controls over the benefits, resulting at least in part from fewer resources being available for such controls, reduced the likelihood of inappropriately submitted claims being denied.

The administration's major proposals for both SNFs and home health care are designed to give the providers of these services increased incentives to operate efficiently by moving them from a cost reimbursement to a prospective payment system. What remains unclear about these proposals is whether an appropriate unit of service can be defined for calculating prospective payments and whether HCFA's databases are adequate for it to set reasonable rates.

Administration officials also have discussed their intention to propose in the future a coordinated payment system for all post-acute care as methods to give providers efficiency incentives. These concepts have appeal, but we have concerns about them similar to those we have for SNF and home health prospective payments.

Finally, the administration is proposing that SNFs be required to bill for all services provided to their Medicare residents rather than allowing outside suppliers to bill. This latter proposal has merit because it would make control over the use of ancillary services significantly easier.

BACKGROUND

Medicare covers up to 100 days of care in a SNF after a beneficiary has been hospitalized for at least 3 days. To qualify for the benefit, the patient must need skilled nursing or therapy on a daily basis. For the first 20 days of SNF care, Medicare pays all the costs, and for the 21st through the 100th day, the beneficiary is responsible for daily coinsurance of $95 in 1997.

To qualify for home health care, a beneficiary must be confined to his or her residence ("homebound"); require part-time or intermittent skilled nursing, physical therapy, or speech therapy; be under the care of a physician; and have the services

furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for skilled nursing; physical, occupational, and speech therapy; medical social services; and home health aide visits. Beneficiaries are not liable for any coinsurance or deductibles for these home health services, and there is no limit on the number of visits for which Medicare will pay.

Medicare covers care in rehabilitation hospitals that specialize in such care and units within acute-care hospitals that also specialize. To qualify, beneficiaries must have one or more conditions requiring intensive and multidisciplinary rehabilitation services on an inpatient basis. In addition, to qualify as a rehabilitation facility, hospitals and units in acute-care hospitals must demonstrate their status by such factors as furnishing primarily intensive rehabilitation services to an inpatient population, at least 75 percent of whom require treatment of 1 or more of 10 specified conditions (for example, stroke or hip fracture). Rehabilitation facilities must also use a treatment plan for each patient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel. Inpatient rehabilitation is treated like any other hospitalization for beneficiary cost-sharing purposes.[2]

Medicare pays SNFs and home health agencies on the basis of their reasonable costs—those that are found to be necessary and related to patient care—up to specified cost limits. For SNFs, limits are imposed on the amount of routine costs—those for general nursing, room and board, and administrative overhead—that will be reimbursed. Separate limits are set for freestanding SNFs in urban and rural areas at 112 percent of mean routine costs. Hospital-based SNF limits are set midway between the freestanding limits and 112 percent of the mean routine costs of hospital-based SNFs in each area. Home health agency cost limits are established at 112 percent of the mean costs of freestanding agencies in urban and rural areas. Hospital-based agencies have the same limits. Separate limits are set for each type of visit (skilled nursing, physical therapy, and so on) but are applied in the aggregate; that is, an agency's costs over the limit for one type of visit can be offset by costs below the limit for another. Both SNF and home health cost limits are adjusted for differences in wage levels across geographic areas. Also, exemptions from the cost limits are available to newly opened SNFs and home health agencies, and exceptions to the limits are available to those that can show that their costs are above the limits for reasons not under their control.

Inpatient rehabilitation care, provided at both rehabilitation hospitals and units of acute-care hospitals, is exempt from Medicare's hospital prospective payment system (PPS), but is subject to the payment limitations and incentives established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under this law, Medicare pays these facilities the lower of the facility's average Medicare allowable inpatient operating costs per discharge or its target amount. The target amount is based on the provider's allowable costs per discharge in a base year,[3] trended to the current year through an annual update factor. A TEFRA facility with inpatient operating costs below its ceiling receives its costs plus 50 percent of the difference between these costs and the ceiling or 5 percent of the ceiling, whichever is less. Rehabilitation facilities receive cost-based payments without regard to the TEFRA limits until they complete a full cost-reporting year, and that year is then used as their base year.

Long-term care hospitals are another category exempted from the hospital PPS. To qualify as long term, hospitals must have an average length of stay of a least 25 days for their Medicare patients. Medicare pays these hospitals on the basis of their costs, subject to TEFRA limits, just like rehabilitation hospitals. The number of long-term care hospitals has grown from 94 in 1986 to 146 in 1994, and Medicare payments to them have increased considerably from about $200 million in 1989 to about $800 million in 1994. However, these hospitals remain a small part of the Medicare program, representing less than 0.5 percent of expenditures, and little research or analysis has been done on them. As a result, little is known about the reasons for the growth that has occurred in the long-term care hospital area.

While the cost-limit provisions of Medicare's cost reimbursement system for SNFs, home health agencies, and rehabilitation facilities give some incentives for providers to control the affected costs, these incentives are considered by health financing experts to be relatively weak, especially for providers with costs considerably below their limit. On the other hand, it is generally agreed that a PPS gives providers increased cost-control incentives. The administration proposes establishing PPSs for SNF and home health care and estimates that Medicare would save more than $10 billion over the next 5 fiscal years. PPS is also being designed for rehabilitation facilities but is not included in the administration's fiscal year 1998 budget proposals.

POST-ACUTE CARE COST GROWTH

The Medicare SNF, home health, and inpatient rehabilitation benefits are three of the fastest growing components of Medicare spending. From 1989 to 1996, Medicare part A SNF expenditures increased over 300 percent, from $2.8 billion to $11.3 billion. During the same period, part A expenditures for home health increased from $2.4 billion to $17.7 billion—an increase of over 600 percent. Rehabilitation facility payments increased from $1.4 billion in 1989 to $3.9 billion in 1994, the latest year for which complete data were available. SNF payments currently represent 8.6 percent of part A Medicare expenditures; home health, 13.5 percent; and rehabilitation facilities, 3.4 percent.

At Medicare's inception in 1966, the home health benefit under part A provided limited post-hospital care of up to 100 visits per year after a hospitalization of at least 3 days. In addition, the services could only be provided within 1 year after the patient's discharge and had to be for the same illness. Part B coverage of home health also was limited to 100 visits per year. These restrictions under part A and part B were eliminated by the Omnibus Reconciliation Act of 1980 (ORA) (P.L. 96-499), but little immediate effect on Medicare costs occurred.

With the implementation of the Medicare inpatient PPS in 1983, use of the SNF and home health benefits was expected to grow as patients were discharged from the hospital earlier in their recovery periods. But HCFA's relatively stringent interpretation of coverage and eligibility criteria held growth in check for the next few years. As a result of court decisions in the late 1980s, HCFA issued guideline changes for the SNF and home health benefits that had the effect of liberalizing coverage criteria, thereby making it easier for beneficiaries to obtain SNF and home health coverage. Additionally, the changes prevent HCFA's claims processing contractors from denying physician-ordered SNF or home health services unless the contractors can supply specific clinical evidence that indicates which particular services should not be covered.

The combination of these legislative and coverage policy changes has had a dramatic effect on utilization of these two benefits in the 1990s, both in terms of the number of beneficiaries receiving services and in the extent these services are used. (App. I contains figures that show growth in SNF and home health expenditures in relation to the legislative and policy changes.) For example, ORA 1980 and HCFA's 1989 home health guideline changes have essentially transformed the home health benefit from one focused on patients needing short-term post-hospital care to one that serves chronic, long-term care patients as well. The number of beneficiaries receiving home health care more than doubled in the last few years, from 1.7 million in 1989 to about 3.9 million in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72. In a recent review of home health care,[4] we found that from 1989 to 1993, the proportion of home health users receiving more than 30 visits increased from 24 to 43 percent and those receiving more than 90 visits tripled, from 6 to 18 percent, indicating that the program is serving a larger proportion of longer-term patients. Moreover, about a third of beneficiaries receiving home health care did not have a prior hospitalization, another possible indication that care for chronic conditions is being provided.

Similarly, the number of people receiving care from SNFs has also almost doubled, from 636,000 in 1989 to 1.1 million in 1996. While the average length of a Medicare-covered SNF stay has not changed much during that time, the average Medicare payment per day has almost tripled—from $98 in 1990 to $292 in 1996. Use of ancillary services, such as physical and occupational therapy, has increased dramatically and accounts for most of the growth in per-day cost. For example, our analysis of 1992 through 1995 SNF cost reports shows that reported ancillary costs per day have increased 67 percent, from $75 per day to $125 per day, while reported routine costs per day have increased only 20 percent, from $123 to $148. Unlike routine costs, which are subject to limits, ancillary services are only subject to medical necessity criteria, and Medicare does relatively little review of their use. Moreover, SNFs can cite high ancillary service use to justify an exception to routine service cost limits, thereby increasing payments for routine services.

Between 1990 and 1996, the number of hospital-based SNFs increased over 80 percent, from 1,145 such agencies to 2,088. Hospitals can benefit from establishing a SNF unit in a number of ways. Hospitals receive a set fee for a patient's entire hospital stay, based on a patient's diagnosis related group (DRG).[5] Therefore, the quicker that hospitals discharge a patient into a SNF, the lower that patient's inpatient hospital care costs are. We found that in 1994, patients with any of 12 DRGs commonly associated with post-hospital SNF use had 4- to 21-percent shorter stays in hospitals with SNF units than patients with the same DRGs in hospitals without

SNF units.[6] Additionally, by owning a SNF, hospitals can increase their Medicare revenues through receipt of the full DRG payment for patients with shorter lengths of stay and a cost-based payment after the patients are transferred to the SNF.

The availability of inpatient rehabilitation beds has also increased dramatically. Between 1986 and 1994, the number of Medicare-certified rehabilitation facilities grew from 545 to 1,019, an 87-percent increase. A major portion of this growth represents the increase in rehabilitation units located in PPS hospitals, which went from 470 to 824 over the same period. Inpatient rehabilitation admissions for Medicare beneficiaries increased from 2.9 per 1,000 in 1986 to 7.2 per 1,000 in 1993, or 148 percent. Some of this increase in beneficiary use was due to increases in the number of acute-care admissions that often lead to use of rehabilitation facilities. For example, the DRG that includes hip replacement grew from 218,000 discharges during fiscal year 1989 to 344,000 in fiscal year 1995. For the same DRG, average length of stay in acute-care hospitals decreased from 12 to 6.7 days over that period.

As was the case with SNFs, beneficiaries admitted to rehabilitation units in 1994 following a stay in an acute-care hospital had shorter average lengths of stay than beneficiaries admitted to rehabilitation hospitals. They also had shorter stays in the acute-care hospital. Moreover, the same scenario that applies to hospital-based SNFs applies to rehabilitation units. The quicker that hospitals discharge a patient to the rehabilitation unit, the lower that patient's acute-care costs are. By having a rehabilitation unit, hospitals can increase their Medicare revenues through receipt of the full DRG payment for patients with shorter lengths of stay and a cost-based payment after the patients are admitted to rehabilitation.

Rapid growth in SNF and home health expenditures has been accompanied by decreased, rather than increased, funding for program safeguard activities. For example, our March 1996 report found that part A contractor funding for medical review had decreased by almost 50 percent between 1989 and 1995. As a result, while contractors had reviewed over 60 percent of home health claims in fiscal year 1987, their review target had been lowered by 1995 to 3.2 percent of all claims (or sometimes, depending on available resources, to a required minimum of 1 percent). We found that a lack of adequate controls over the home health program, such as little intermediary medical review and limited physician involvement, makes it nearly impossible to know whether the beneficiary receiving home health care qualifies for the benefit, needs the care being delivered, or even receives the services being billed to Medicare. Also, because of the small percentage of claims now selected for review, home health agencies that bill for noncovered services are less likely to be identified than they were 10 years ago. Similarly, the low level of review of SNF services makes it difficult to know whether the recent increase in ancillary service use is legitimate (for example, because patient mix has shifted toward those who need more services) or is simply a way for SNFs to get more revenues.

Medicare's peer review organization (PRO) contractors have responsibility for oversight of Medicare inpatient rehabilitation hospitals and units from both utilization and quality-of-care perspectives. However, the PROs' emphasis has changed in recent years, with a greater focus on quality reviews and less emphasis on case review. In fact, the current range of work for PROs requires no specific review for the appropriateness of inpatient rehabilitation use.

Finally, because relatively few resources have been available for auditing end-of-year provider cost reports, HCFA has little ability to identify whether home health agencies, SNFs, and rehabilitation facilities are charging Medicare for costs unrelated to patient care or other unallowable costs. Because of the lack of adequate program controls, it is quite possible that some of the recent increase in home health, SNF, and rehabilitation facility expenditures stems from abusive practices. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), also known as the Kassebaum-Kennedy Act, has increased funding for program safeguards. However, per-claim expenditures will remain below the level they were in 1989, after adjusting for inflation. We project that, in 2003, payment safeguard spending as authorized by Kassebaum-Kennedy will be just over one-half of the 1989 per-claim level, after adjusting for inflation.

ADMINISTRATION'S PROPOSALS FOR PROSPECTIVE PAYMENT SYSTEMS

The goal in designing a PPS is to ensure that providers have incentives to control costs and that, at the same time, payments are adequate for efficient providers to furnish needed services and at least recover their costs. If payments are set too high, Medicare will not save money and cost-control incentives can be weak. If payments are set too low, access to and quality of care can suffer.

In designing a PPS, selection of the unit of service for payment purposes is important because the unit used has a strong effect on the incentives providers have for

the quantity and quality of services they provide. Taking into account the varying needs of patients for different types of services—routine, ancillary, or all—is also important. A third important factor is the reliability of the cost and utilization data used to compute rates. Good choices for unit of service and cost coverage can be overwhelmed by bad data.

Proposal for a SNF PPS

We understand that the administration will propose a SNF PPS that would pay per diem rates covering all facility cost types and that payments would be adjusted for differences in patient case mix. Such a system is expected to be similar to HCFA's ongoing SNF PPS demonstration project that is testing the use of per diem rates adjusted for resource need differences using the Resource Utilization Group, version III (RUG-III) patient classification system.[7] This project was recently expanded to include coverage of ancillary costs in the prospective payment rates.

An alternative to the proposal's choice of a day of care as the unit of service is an episode of care—the entire period of SNF care covered by Medicare. While substantial variation exists in the amount of resources needed to treat beneficiaries with the same conditions when viewed from the day-of-care perspective, even more variation exists at the episode-of-care level. Resource needs are less predictable for episodes of care. Moreover, payment on an episode basis may result in some SNFs inappropriately reducing the number of covered days. Both factors make a day of care the better candidate for a PPS unit of service. Furthermore, the likely patient classification system, RUG-III, is designed for and being tested in a per diem PPS. On the other hand, a day-of-care unit gives few, if any, incentives to control length of stay, so a review process for this purpose would still be needed.

The states and HCFA have a lot of experience with per diem payment methods for nursing homes under the Medicaid program, primarily for routine costs but also, in some cases, for total costs. This experience should prove useful in designing a per diem Medicare PPS.

Regarding the types of costs covered by PPS rates, a major contributor to Medicare's SNF cost growth has been the increased use of ancillary services, particularly therapy services. This, in turn, means that it is important to give SNFs incentives to control ancillary costs, and including them under PPS is a way to do so. However, adding ancillary costs does increase the variability of costs across patients and places additional importance on the case-mix adjuster to ensure reasonable and adequate rates.

Turning to the adequacy of HCFA's databases for SNF PPS rate-setting purposes, our work, and that of the Department of Health and Human Services' (HHS) Inspector General, has found examples of questionable costs in SNF cost reports. For example, we found extremely high charges for occupational and speech therapy with no assurance that cost reports reflected only allowable costs.[8] Cost-report audits are the primary means available to ensure that SNF cost reports reflect only allowable costs. However, the resources expended on auditing cost reports have been declining in relation to the number of SNFs and SNF costs for a number of years. The percentage of SNFs subjected to field audits has decreased as has the extent of auditing done at the facilities that are audited. Under these circumstances, we think it would be prudent for HCFA to do thorough audits of a projectable sample of SNF cost reports. The results could then be used to adjust cost-report databases to remove the influence of unallowable costs, which would help ensure that inflated costs are not used as the base for PPS rate setting.

Proposal for a Home Health PPS

The summary of the administration's proposal for a home health PPS is very general, saying only that a PPS for an appropriate unit of service would be established in 1999 using budget neutral rates calculated after reducing expenditures by 15 percent. HCFA estimates that this reduction will result in savings of $4.7 billion over fiscal years 1999 through 2002.

The choice of the unit of service is crucial, and there is limited understanding of the need for and content of home health services to guide that choice. Choosing either a visit or an episode as the unit of service would have implications for both cost control and quality of care, depending on the response of home health agencies. For example, if the unit of service is a visit, agencies could profit by shortening the length of visits. At the same time, agencies could attempt to increase the number of visits, with the net result being higher total costs for Medicare, making the per-visit choice probably not appropriate. Using an episode of care over a period of time such as 30 or 100 days as the unit of service has a greater potential for controlling costs. However, agencies could gain by reducing the number of visits during that period, potentially lowering quality of care. If an episode of care is chosen as the

unit of service, HCFA would need a method to ensure that beneficiaries receive adequate services and that any reduction in services that can be accounted for by past overprovision of care does not result in windfall profits for agencies. In addition, HCFA would need to be vigilant to ensure that patients meet coverage requirements, because agencies would be rewarded for increasing their caseloads. HCFA is currently testing various PPS methods and patient classification systems for possible use with home health care, and the results of these efforts may shed light on how to best design a home health PPS.

We have the same concerns about the quality of HCFA's home health care cost-report databases for PPS rate-setting purposes that we do for the SNF database. Again, we believe that adjusting the home health databases, using the results of thorough cost-report audits of a projectable sample of agencies, would be wise.

We are also concerned about the appropriateness of using current Medicare data on visit rates to determine payments under a PPS for episodes of care. As we reported in March 1996, controls over the use of home health care are virtually nonexistent. Operation Restore Trust, a joint effort by federal and state agencies in several states to identify fraud and abuse in Medicare and Medicaid, found very high rates of noncompliance with Medicare's coverage conditions in targeted agencies. For example, in a sample of 740 beneficiaries drawn from 43 home health agencies in Texas and 31 in Louisiana that were selected because of potential problems, some or all of the services received by 39 percent of the beneficiaries were denied. About 70 percent of the denials were because the beneficiary did not meet the homebound definition. Although these are results from agencies suspected of having problems, they illustrate that substantial amounts of noncovered care are likely to be reflected in HCFA's home health care utilization data. For these reasons, it would also be prudent for HCFA to conduct thorough on-site medical reviews of a projectable sample of agencies to give it a basis to adjust utilization rates for purposes of establishing a PPS.

Rehabilitation PPS Also Is Being Developed

The administration has not proposed a PPS for rehabilitation facilities, but HCFA has an ongoing research project to develop such a system. A report detailing a model for a PPS is currently undergoing review. The research was directed at designing a per-episode payment system adjusted for case mix, using a measure of patient functional status—for example, the patient's mobility—as the adjuster. In general, this and other research has shown that patients in the rehabilitation facilities are more homogeneous than those in SNFs or home health care. Because the goals for the care are also more homogeneous and defined, an episode may be a reasonable choice for a unit of service. Again, the per-episode payment should be structured to reduce the incentives for premature discharge, and adequate review mechanisms to prevent such discharges and other quality problems would be needed.

As with SNFs and home health care, we have concerns about the reliability of HCFA's databases for rate-setting purposes for rehabilitation hospitals because of the low levels of utilization review and cost-report auditing. As we stated earlier, HCFA should do enough audits and medical review to enable it to adjust its databases to remove the effects of any problems. HCFA would also need an adequate review system under a PPS because rehabilitation facilities would probably have incentives to increase their caseloads, cut corners on quality, or both.

Long-term Care Hospital Proposal

HCFA is not currently studying a PPS for long-term care hospitals. Rather, the administration is proposing that any hospitals that newly qualify for long-term care status be paid under the regular inpatient hospital PPS. Also, HCFA officials told us that the agency plans to recommend in the future a coordinated payment system for post-acute care and that long-term care hospitals are being considered for inclusion under such a payment system. I will discuss the coordinated payment concept later in this statement.

CONSOLIDATED BILLING FOR SNFS

The administration has also announced that it will propose requiring SNFs to bill Medicare directly for all services provided to their beneficiary residents except for physician and some practitioner services. We support this proposal as we did in a September 1995 letter to the House Ways and Means Committee. We and the HHS Inspector General have reported on problems, such as overutilization of supplies, that can arise when suppliers bill separately for services for SNF residents.

A consolidated billing requirement would make it easier for Medicare to identify all the services furnished to residents, which in turn would make it easier to control payments for those services. The requirement would also help prevent duplicate bil-

lings for supplies and services and billings for services not actually furnished by suppliers. In effect, outside suppliers would have to make arrangements with SNFs under such a provision so that nursing homes would bill for suppliers' services and would be financially liable and medically responsible for the care.

"BUNDLING" POST-ACUTE CARE SERVICES

There can be considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the three post-acute care settings. For example, physical therapy and other rehabilitation services can be provided by a SNF, a home health agency, or a rehabilitation facility. Both HCFA and the prospective payment assessment commission (ProPAC) have noted that the ability to substitute care among post-acute settings may contribute to inappropriate spending growth, even after payment policies are improved for individual provider types.[9] Although prospective payment encourages providers to deliver care more efficiently, facility-specific payments may encourage them to lower their costs by shifting services to other settings. The administration has therefore announced that it will in the future recommend a coordinated payment system for post-acute care services. Such a system will be designed to help ensure that beneficiaries receive quality care in the appropriate settings, and that any patient transfers among settings occur only when medically appropriate rather than in efforts to generate additional revenues. While no details are available about how a coordinated post-acute payment system would operate, presumably it will entail consolidated (bundled) payments to one entity for the different types of providers. In fact, ProPAC has suggested a system that bundles acute and post-acute payments.

One of the most important design issues in a bundled payment approach is deciding which provider would receive the payment. Because this provider would have to organize and oversee the continuum of services for beneficiaries, it would bear the risk that payments would not cover costs. Options for this role include an acute-care hospital, a post-acute care provider, or a provider service network.

Another important design issue involves developing an appropriate payment rate. Under the current inpatient PPS, payment rates are based on DRGs. But research has shown that DRGs are poor predictors of post-acute care use. In extending PPS to include post-acute services, future post-acute care utilization needs to be accurately predicted to ensure that prospective rates are adequate to cover costs but also give an incentive to provide cost-effective care.

Bundling acute and post-acute care would have a number of potential advantages and disadvantages. Optimally, bundling of payments would encourage continuity of care. If, for example, the inpatient hospital has a greater stake in the results, bundling could lead to both better discharge planning as well as improved transfer of information from the hospital to the post-acute provider. Bundling payments to the hospital could also eliminate a PPS hospital's financial incentive to discharge Medicare patients before they are ready, because patients discharged prematurely may require extensive post-acute services for which the hospital is liable. Furthermore, bundling with an appropriate payment rate would give providers more incentive to furnish the mix of inpatient and post-hospital services that yield the least costly treatment of an entire episode of care and thus help control growth in the volume of post-acute services. Finally, to the extent that the bundling arrangement promotes joint accountability, combining responsibility for hospital and post-acute providers could lead to better outcomes.

There are a number of potential disadvantages as well. Because bundled payments would represent some level of financial risk, whoever received the bundled payment would need to have the resources to accept the risk. Moreover, bearing risk often gives incentive to shift the risk to others and raises concerns about quality. A key to the success of any bundling system is coordinating care and continuously monitoring a patient during the entire episode. However, some providers might not have the capabilities to do this. For example, if, as ProPAC has suggested, both acute- and post-acute care were bundled and if hospitals received the bundled payment, some hospitals might not have the resources, information, or expertise to properly manage patients' post-acute care. The same could be said for SNFs and home health agencies. An additional concern is that whoever received the bundled payment could have dominance over the other providers and make choices about acute- and post-acute care settings that are driven primarily by concerns about cost. For example, hospitals might try to maximize their profit by limiting post-acute services or be tempted to screen admissions to avoid patients with high risks of heavy post-hospital care.

Another important issue involves how to deal with home health patients who have had no prior hospitalization. About a third of home health visits fall into this cat-

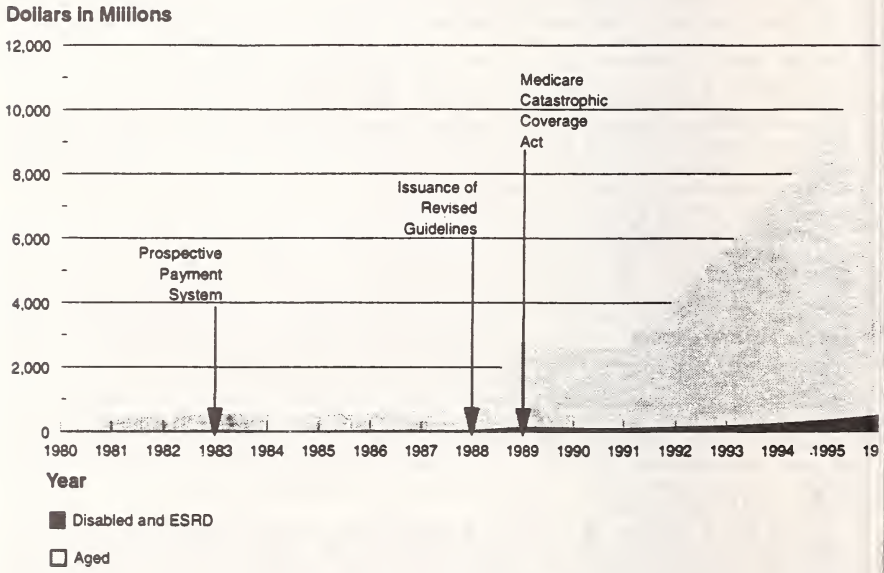
egory. A bundled payment system would not affect home health agency incentives for such patients. Finally, beneficiary advocacy groups have expressed concern about potential harmful effects of this system on patients' freedom of choice and how the quality and appropriateness of care could be ensured.

In conclusion, it is clear from the dramatic cost growth for SNF, home health, and rehabilitation facility care that the current Medicare payment mechanisms for the providers need to be revised. As more details concerning the administration's or others' proposals for revising those systems become available, we would be glad to work with the Committee and others to help sort out the potential implications of suggested revisions.

APPENDIX I

MEDICARE SKILLED NURSING FACILITY AND HOME HEALTH EXPENDITURES, 1980-96

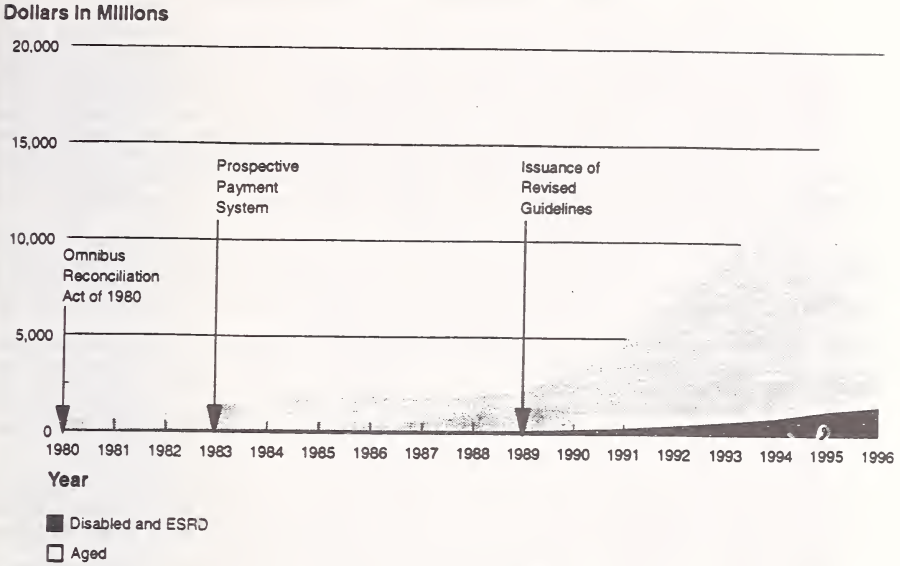
Figure I.1: Medicare Skilled Nursing Facility Expenditures, 1980-96



Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

Figure I.2: Medicare Home Health Expenditures, 1980-96



Note: ESRD = end-stage renal disease.

Source: HCFA's Office of the Actuary.

ENDNOTES

[1] Expenditure data for inpatient rehabilitation were obtained from the Prospective Payment Assessment Commission.

[2] The beneficiary is responsible for a deductible, $760 in 1997, and coinsurance for each day over 60 days during a spell of illness. A spell of illness ends when the beneficiary has not been in a hospital or SNF for 60 days. A transfer from an acute-care hospital to a rehabilitation hospital or unit does not result in a second deductible because the patient is in the same spell of illness.

[3] The base year depends on when the rehabilitation hospital or unit began operating. For those operating in 1987 or earlier, the base year is usually the cost-reporting year begun during fiscal year 1987.

[4] *Medicare: Home Health Utilization Expands While Program Controls Deteriorate* (GAO/HEHS–96–16, Mar. 27, 1996). This report includes an extensive discussion of the reasons for home health care cost growth.

[5] DRGs are sets of diagnoses that are expected to require about the same level of hospital resources to treat beneficiaries suffering from them.

[6] *Skilled Nursing Facilities: Approval Process for Certain Services May Result in Higher Medicare Costs* (GAO/HEHS–97–18, Dec. 20, 1996). This report also includes information on cost growth for SNF services and the characteristics of Medicare beneficiaries who receive SNF care.

[7] RUG-III is a method for classifying SNF residents according to health characteristics and the amount and type of resources they need.

[8] *Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes* (GAO/HEHS–95–23, Mar. 30, 1995).

[9] HCFA Administrator's statement on "Reforming the Medicare Home Health Benefit," before the Subcommittee on Health and Environment, House Committee

on Commerce (Mar. 5, 1997), and *Report and Recommendations to the Congress* (Washington, D.C.: ProPAC, Mar. 1, 1997).

PREPARED STATEMENT OF THOMAS A. SCULLY

Good morning. I am Tom Scully, President and CEO of the Federation of American Health Systems ("The Federation"), and I am pleased to be here today to testify before the Committee on post-acute payment policy. The Federation is the representative of 1,700 investor-owned and managed health care organizations, which include almost 1,100 of the nation's acute-care hospitals, and over 600 specialty hospitals. While we principally represent acute-care PPS hospitals, we also represent a broad cross-section of PPS-exempt providers. Particularly important for this hearing, the Federation's members include the single largest PPS-exempt providers in the rehabilitation, psychiatric and long-term care sectors, and the majority of all PPS-exempt freestanding specialty hospitals.

HEALTHSOUTH Corporation, is the nation's largest rehabilitation provider with 60 freestanding rehabilitation hospitals, and over 700 outpatient clinics. Another Federation member, Horizon/CMS, has 33 freestanding hospitals and over 250 outpatient rehabilitation centers. Together, they represent the vast majority of the nation's freestanding inpatient rehabilitation hospitals.

Magellan Health Services is nation's largest behavioral health care provider with nearly 100 psychiatric hospitals and 150 outpatient clinics. Magellan also manages mental health benefits for over 12 million Americans through arrangements with large private and public employers, and state Medicaid programs. Together with numerous other member companies, the Federation represents over 50% of all psychiatric hospitals, and hundreds of additional units in acute-care facilities.

In the long term care sector, Vencor is the nations largest provider of long-term care services with 38 long-term care hospitals, and 311 nursing centers. Horizon/CMS has 15 long-term care hospitals, and American Transitional Hospitals operates 11 long-term hospitals. In total, the Federation represents over 35% of all long-term care hospitals, including the majority of freestanding hospitals.

Finally, in addition to these providers, Federation acute-care hospital members provide a substantial amount of care in these areas as well.

Because the Federation represents such a broad cross-section of the PPS-exempt provider community, we are uniquely qualified to comment on proposed changes contained in the President's FY 98 Budget proposals and recommendations made by ProPAC affecting these facilities. We appreciate the opportunity to appear before the Committee to address these issues today.

The Federation has been and remains strongly supportive of the Committee's efforts to reform and modernize the Medicare program. We know this will take a great deal of work and that costs must be reduced while quality and outcomes continue to be improved. We are willing to shoulder a fair share of the Medicare cost containment burden and think we can meet this challenge if we have the opportunity to work closely with the Committee and Congress on new policy approaches.

However, there are two cautionary notes that must be taken into account as we design the plans to get there. First, PPS-exempt providers are very different from PPS hospitals in the types of services they provide, the types of patients they treat and the way they are reimbursed. Second, the President's Budget imposes on the PPS-exempt sector a disproportionate amount of the budget cuts in the Medicare program. This may have unintended consequences that exacerbate existing problems rather than moving the program forward.

Compounding the effect of the reductions are several important distinctions between PPS-exempt and PPS hospitals the Committee should consider. Unlike PPS providers, PPS-exempt providers are paid only their actual allowable costs. PPS-exempt providers also treat a higher proportion of Medicare patients than most acute-care hospitals, further limiting the potential for cost-shifting. For example, Medicare constitutes 60% of HEALTHSOUTH's patient mix, and 75% of Vencor's patient mix. The average acute-care hospital has a 40—5% Medicare patient mix. Despite their higher percentage of Medicare patients, PPS-exempt providers do not receive Medicare disproportionate share payments (DSH). As a result of these differences, proposed reductions can have a more pronounced effect on cost-based exempt providers.

We recognize that there are short-term and long-term measures under consideration. In the long-term, all the Federation members agree that a well thought out, case mix adjusted prospective payment system may be the most effective way to control costs and maintain the proper incentives for efficiency and improved quality. In the short-term, while we begin moving in that direction, we have to find ways to control costs and generate savings in this area. We want to work with you to

achieve both goals. In fact, it is imperative that we be allowed to provide this kind of input because there are short-term policies, some prominently featured in the President's Budget proposal, that will actually take us in the wrong direction—further away from our mutual long-term goal of a cost-effective, quality enhancing, prospective payment system.

THE SHORTER TERM—ACHIEVING SAVINGS IN THE CURRENT SYSTEM

Rebasing

Chief among the "wrong-direction" approaches is the President's proposal to rebase TEFRA limits for all PPS-exempt providers whose base year comes before 1991. The effect of such a proposal will be to reward hospitals that have had increasing costs and to penalize hospitals that have controlled their costs. Current TEFRA limits have successfully encouraged facilities to deliver care in the most cost-effective manner. Many well managed facilities have been able to maintain their cost levels within the limits without adversely affecting the quality of patient care. For example, HEALTHSOUTH has demonstrated decreases in Medicare charges, cost per day and cost per discharge from 1994–1996, while improving outcomes performance for beneficiaries. Inefficient hospitals which have not taken steps to control their costs are penalized by the imposition of TEFRA limits, as envisioned by Congress when the TEFRA system was implemented. The President's proposal to now recalculate TEFRA limits would result in a redistribution of Medicare funds away from efficient hospitals which have worked hard over the years to control their costs to inefficient providers who have not brought their costs under control.

As ProPAC observes, rebasing would penalize hospitals that have constrained their costs (often our hospitals) by paying them less. At the same time, facilities that had not become more efficient would be rewarded by higher payments. I would assume Congress wants to encourage efficiency—as a PPS system would—not penalize it. We hope the committee would not adopt a proposal with such perverse effects.

The President's proposal would also establish arbitrary floors and ceilings on TEFRA limits. The proposal would establish a floor of 70% of the national average and a ceiling of 150%. This approach disregards critically important factors such as patient type and acuity level treated in each type of PPS-exempt facility, and will only serve as a disincentive for PPS-exempt providers to treat sicker, more complex patients.

In addition, it must be pointed out that at the same time the Administration proposes such dramatic ill-conceived changes, it is ignoring tools already available to the Secretary to provide relief for efficient hospitals which have exceeded their limits due to legitimate factors. An exceptions process already exists by which older facilities with lower TEFRA limits can receive adjustments or a new base year—rebasing on a case-by-case basis.

Inflation Update Cuts

As an alternative to rebasing to produce Medicare savings, and in view of Congress' imperative to preserve the Medicare Part A trust fund, Federation members are prepared to work with the Committee to establish differential market basket updates based on historical costs. Even though ProPac recommended a 2% inflation update for PPS-exempt facilities, our members are prepared to accept a lower update to avoid ill-conceived, budget-driven rebasing proposals. For example, the Committee should examine reducing target amount updates for those facilities with costs consistently below their TEFRA limits, while increasing updates for hospitals that can document legitimate reasons for consistently exceeding their limits. We understand the need to make adjustments for some older facilities, but such relief should not result in undue penalties for providers that have responded to the existing incentives for efficiency.

Elimination of Efficiency Incentive Payments

A closely-related proposal included in the Administration's Budget requires the elimination of incentive payments for provider efficiency. Currently, PPS-exempt facilities may receive certain incentive payments to encourage them to, and reward them for, reducing their costs to the Medicare program. In such cases, Medicare splits the additional savings achieved when a PPS-exempt provider manages to come in below its projected cost or target amount with the provider, giving the provider the lesser of half the difference between the target amount and the provider's actual cost or five percent of the target amount. As Medicare shares in the savings when facilities come in below their targets, so Medicare also shares in the risk that a facility may not be able to meet its target and may have to exceed it. In such cases, facilities with operating costs above the target amount receive the target amount plus 50 percent of the difference between the target amount and the actual

cost, up to 110 percent of the target amount. In this way, Medicare provides a strong disincentive to avoid going over the target amount, and an even stronger incentive to try to beat the target amount.

The President's proposal would eliminate the incentive payment for providers who keep costs below the TEFRA rate. In addition, for providers with higher costs, it would subsidize only those costs in excess of 110% of the TEFRA rate, up to 20% of the rate. That is, TEFRA hospitals would be expected to bear more of the risk and none of reward for efficiency.

Absent a fully developed prospective payment system, the existing incentive policy seems to be exactly the right type of incentive. Its elimination makes no sense and runs counter to the development of a PPS system. For example, PPS for acute-care hospitals has been quite successful in encouraging efficiency by rewarding hospitals that control costs below DRG payment levels with 100% of the of the savings.

Finally, it would be imprudent to make major changes to the TEFRA system just prior to establishment of PPS for excluded facilities. The Federation would recommend that Congress seek less dramatic changes to the current payment system and focus on the development of a sound prospective payment system for PPS-exempt facilities.

15% Capital Reduction

The Administration has proposed to reduce PPS-exempt capital reimbursement by 15%. This is a harsh, immediate cut that hits PPS-exempt facilities hard. If capital reimbursement is reduced, it should be to a level no less than that currently proposed for acute-care hospitals, and should be phased in, as it was for acute-care hospitals. Under the President's Budget proposal, acute-care hospitals would be reimbursed for 90% of capital costs compared to the proposed 85% for PPS-Exempt providers. Further, acute-care facilities have experienced the 10% reduction in the past and have had the opportunity, albeit with great difficulty, to adjust. PPS-exempt have always been reimbursed 100% of capital. Not only is the reduction larger and more immediate, but the impact of such a reduction is more pronounced for PPS-exempt facilities since they are reimbursed only at cost to begin with and traditionally have a higher percentage of Medicare patients.

In addition, reducing capital reimbursement would have some significant long-term negative effects. Many of our PPS-exempt hospitals make large capital investments to upgrade facilities, enabling them to reduce operating costs. Reducing capital reimbursement could discourage companies from making these investments or reinvesting in older facilities. Additionally, it probably has a disproportionate impact on facilities in the South and West, which often have newer facilities with higher capital and depreciation costs. In contrast, an overall update reduction impacts all providers the same by region.

Redefinition of Hospital Transfers

While there are differences of opinion among Federation members, a majority oppose the Administration's proposal to redesignate as a transfer, rather than a discharge, the movement of a patient from a PPS setting to a PPS-exempt setting. The acute-care providers are adamantly opposed to this approach since they believe it undercuts the effectiveness of the PPS system and the successes it has reaped in reducing length of stay and cost to the Medicare program. It will create perverse incentives to keep patients in inpatient settings, and penalize providers who have increased effectiveness.

Furthermore, ProPAC's data shows that hospitals do not appear to be discharging patients "early" to PPS-exempt facilities. According to ProPac, in most cases, beneficiaries who used a post-acute provider immediately after being discharged had longer hospitals stays than those who did not. For example, patients who were hospitalized for a stroke and subsequently transferred to a post-acute provider, had an ALOS of 9.4 days in the acute-care facility. By contrast, acute-care ALOS for those who did not use post-acute care was 6.5 days. Acute-care facilities also point out that the bulk of the cost in a hospital stay is front-loaded and any payment made on a per diem basis would have to account for the increased intensity of resources consumed on the front end of a hospital stay.

Most of the PPS-exempt members also question this proposal, citing doubts about whether the proposal will save Medicare any money. They fear the acute-care hospitals will have an incentive to keep patients longer, deferring or jeopardizing use of other, possibly more appropriate or cost-effective rehabilitation or specialty care settings. While this proposal is "scored" as savings by OMB, ProPAC's views and reality would argue that it may, indeed, increase costs.

Repeal of New Provider Exemption

ProPAC has proposed an elimination of the automatic exemption from TEFRA limits for new providers. Currently, new providers have two years to establish their target amounts, during which they are paid on an actual cost basis. ProPAC notes the perverse incentive for a new provider to inflate its costs during the base setting period and instead would only allow these new providers to receive the national average target amount for each facility type during their base-setting period. Some of our members agree that the new provider exemption is primarily an incentive to attract new providers that may no longer be needed or affordable. Others note that there are areas where new providers may be needed and without the new provider exemption, it will be hard for these new providers to receive adequate reimbursement for their sicker patients. In their view, it creates a disincentive to treat these sicker patients.

THE LONGER TERM—CREATING THE RIGHT SYSTEM

As discussed in my opening remarks, we believe that the best way to achieve efficiencies and create the right incentives in this part of the system long-term is through the development of well-thought out, case-mix adjusted prospective payment systems for post-acute PPS-exempt providers. Some sectors will be ready earlier than others, such as home health and skilled nursing facilities, while others will not be able to move in that direction until much more work is done to see if prospective payment is even possible, such as psychiatric services.

Prospective Payment System for Rehabilitation Hospitals

The Administration has been looking to phase-in prospective payment systems for specific types of PPS-exempt providers, notably rehabilitation hospitals. The Federation's members providing rehabilitation services—both in freestanding and in hospital units—are supportive of moving toward a prospective payment system as soon as practicable, but have strong reservations and currently oppose the patient classification system being developed by RAND Corporation under contract to the Health Care Financing Administration.

The Federation's rehabilitation hospital members are concerned that the RAND data being used to develop the patient classification system commonly referred to as functional related groups or FRG's do not reflect critically important elements. Specifically, the data sample used by RAND included information surveyed from only two member hospitals (ignoring nearly 70% of all freestanding rehab hospitals). Further, the patient classification system does not account for co-morbidities or for the length of time a patient has been an inpatient of an acute-care hospital prior to admittance to a rehabilitation hospital or unit. These are critical factors in determining anticipated resource needs of rehab patients. Our members are also concerned about the RAND study's intention to include long term patients within the rehab patient classification system, since these are distinct patient types that are not comparable. We are interested in supporting PPS for rehab—but most definitely not this PPS that excluded the bulk of the country's rehab providers.

PPS For Long-Term Care Hospitals

The National Association of Long Term Hospitals commissioned the Lewin Group to perform a feasibility study of a prospective payment system for long term hospitals in 1995. The results were promising and the study was offered to ProPAC and HCFA for their comments and input. The Lewin Group is proceeding with the study and is expected to have a patient classification system completed by approximately May of 1997, a payment system by the Fall of 1997 and a final report ready by the Summer of 1998.

The Secretary of HHS was charged by Congress to develop PPS for exempt hospitals, including long-term care hospitals, more than a decade ago. There is no evidence that HHS or HCFA has completed any substantial work on such a system.

Psychiatric Hospitals Must Continue To Be Considered Separately

There is virtual unanimity, including at HCFA, that psychiatric services, because by their nature they are hard to classify and predict, may have the farthest to go in order to develop a prospective payment system. While significant research has been done to evaluate prospective payment system options for many other types of providers, the limited research which has been done to date related to psychiatric facilities has not resulted in a viable methodology to classify patients in a manner which accurately predicts resource consumption. For example, the resources consumed by a patient admitted in the surgical department of a general hospital in need of a tonsillectomy are predictable with a narrow range of deviation from expected cost levels. The same is not true for a patient admitted to a psychiatric hos-

pital with a diagnoses of psychosis, who may or may not need an MRI, and may or may not immediately respond to an array of various therapies. Until a methodology is developed which accurately predicts resource consumption, a meaningful prospective payment system for psychiatric systems cannot be developed. Accordingly, while FAHS members support the development of prospective systems, this may be an even longer term goal for psychiatric facilities.

SNF PPS

The Administration has included a proposal to establish a per diem prospective payment system beginning in FY 1998. While our members with SNFs generally agree that prospective payment is needed and they are ready to transition to such a system, they are sure to emphasize that there still are a substantial details to be addressed regarding its implementation. Any prospective payment system must incorporate accurate case-mix adjustments, along with geographic and other valid adjustments. For example, according to ProPAC, while hospital-based SNFs have higher cost-per-day, they have lower costs-per-stay. More analysis needs to be done, but this tends to indicate higher resource utilization per day by patients in hospital settings. How will these types of differences in acuity of patient and intensity of resource utilization be taken into account? Perhaps, a case-mix adjusted episodic system would be more appropriate. How will the need for high cost ancillary services such as rehabilitation therapies, which varies greatly among SNF patients, be fairly addressed? The HCFA must work closely with the health care community to develop appropriate reimbursement methodologies. This proposal should be carefully developed by HCFA through full notice and comment rulemaking to achieve maximum industry input.

HHA PPS

The Administration also proposes to implement a prospective payment system for home health payment beginning in 1999. While the Federation supports the establishment of PPS for home health, many of the same concerns about proceeding with caution apply. The home health industry has developed a PPS proposal that deserves serious consideration and should serve as the basis for the legislative provisions. Any regulatory components should be developed in close consultation with the industry and through full notice and comment procedures.

Unified Post-Acute Payment System

The Administration has included in their budget a proposal to allow the Health Care Financing Administration (HCFA) to develop a unified post-acute payment system. While we do generally support the concept of a case-mix adjusted prospective payment system for all post-acute services, we must emphasize that it is only conceptual support at this time. Although we believe this is an appropriate direction for further study, neither the Congress nor the industry, (nor apparently HCFA) has seen any of the crucial elements of such systems spelled out. How would payments be adjusted for case-mix? Would payment be on a per-day or per-episode basis? What exceptions and special payment rules would apply. How would it be phased in? How would the prospective systems vary across the different provider types: rehab, long-term hospital, skilled nursing and home health?

Given the need to resolve such large issues, we are extremely concerned that the HCFA is proposing that it be given the authority to implement prospective payment using interim final rulemaking authority. This would mean that HCFA could implement major program change, affecting a significant portion of the health care sector, without the opportunity for Congress, the industry or the beneficiaries to have any input. While we are supportive of HCFA and enjoyed a good working relationship with the Administrator and the staff, we would certainly hope that this Committee would not agree to such an unprecedented approach. Such a "blind" delegation of policymaking would set the stage for a potential policy debacle that will end up back in Congress' lap.

Conclusion

In conclusion, we are concerned about both the level of cuts and the direction of many of the policies included in the President's Budget. PPS-exempt facilities are becoming increasingly important players in delivering care to the Medicare and non-Medicare populations alike. We know we are, and have to be, part of the solution. We want to work with the Committee to develop policies that not only will achieve an appropriate level of Medicare savings, but also will help promote the right incentives and provide the best care in the most appropriate setting for the patient. Thank you for this opportunity to share our views with you today.

PREPARED STATEMENT OF MICHAEL WALKER

Chairman Roth and Members of the Committee, I am Michael Walker, Chairman and CEO of Genesis Health Ventures, Inc. Genesis is a diversified provider of health care services to the elderly, serving more than 75,000 customers each day through five regional eldercare networks in the eastern United States. Approximately one-third of these customers are residents of nursing facilities that we own or manage in 12 states, including Delaware, Florida, West Virginia, Vermont and Rhode Island. I am speaking today on behalf of the American Health Care Association, a federation of 50 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. On behalf of AHCA's members, and the one million plus residents of our member facilities, thank you for the opportunity to speak at this important hearing.

Let me begin by reiterating our support for the direction of Medicare reform taken by this Committee in the last Congress. We support increasing choices for seniors, modernizing and transforming Medicare into a more market-oriented system, and moving skilled nursing facilities toward an episodic Prospective Payment System (PPS). Senator Roth, your leadership in this continuing effort has been outstanding, and I commend you for it.

It is difficult to single out members of this committee because so many have been helpful, but we also want to thank Senator Hatch for his leadership on Prospective Payment Systems and Senators Grassley and Conrad for their leadership on rural and quality issues important to our industry. We look forward to working with you this year, not only to ensure the solvency of the Medicare Trust Fund, but to reform Medicare policies and create a more competitive and fair system.

Mr. Chairman, today's hearing is concerned with how to change certain policies within the existing Medicare fee-for-service system as it relates to care received by beneficiaries once they leave an acute-care hospital bed. As I will testify, a number of changes in the way that post-hospital services are paid for have been proposed, and should be enacted in order to contain costs and foster more appropriate care. One of many questions is why an older person should have to go into a hospital at all in order to receive the care he or she really needs. Candidly, these changes must be made, but they must lead us to something more, to something fundamentally different - to a time when the Medicare program will no longer purchase millions of individual units of service from hundreds of thousands of different providers on behalf of its millions of elderly beneficiaries.

This program that is so vitally important to older people cannot be preserved, and will not deliver full value to its clients or to taxpayers, until it is changed from being a direct purchaser of particular services to becoming a funding source for comprehensive health solutions chosen by beneficiaries in a competitive market place. (Parenthetically, Mr. Chairman, I also believe that the major portion of the Medicaid program that goes to fund care for the elderly should also be realigned along this same principle). True reform of our eldercare system cannot happen if we continue to insist on maintaining multiple funding streams aimed at the same client, with no particular program, provider, or level of government being responsible for either the cost of care or the well-being of that client. However, if the substantial public investment in care of older people is redirected to empower consumers to act in a true competitive market, the results will be dramatically lower costs and better care. I urge this Committee to move reforms in this direction as you search for solutions to the Medicare crisis now, and down the road, to the certain long term care funding crisis.

Let me now get right to the point of this hearing on post-acute payment policies by first responding to the Administration's 1998 Budget and its proposals affecting SNFs.

- First of all, I'm glad to say that **the budget provisions concerning skilled nursing facilities, primarily the Administration's Prospective Payment System, were scored by the Congressional Budget Office (CBO) at $7.7 billion dollars over five years** - more than $700 million over what the President requested from our industry. We could support the President's proposed level of $7 billion over five years, but feel any more would inhibit our ability to offer quality skilled nursing facility (SNF) services and to provide healthy competition in the post acute sector.

  We also would like to point out that separate salary equivalency regulations issued on March 28th by the Health Care Finance Administration will save $1.7 billion over four years, meaning that our industry is being asked to contribute far more in savings than meets the eye. CBO's out year scoring of the PPS also shows SNFs contributing far more than was requested by the Administration. We urge you to take these factors into account before allocating reimbursement reductions.

- We **support the Administration's case mix adjusted, per diem Prospective Payment System (PPS) proposal** and are working with the Health Care Financing Administration (HCFA) on its development. We will want to see the final language to be sure it includes an outlier policy and that the case mix adjustment methodology covers the full range of SNF subacute services being provided in our facilities. Nevertheless, HCFA's per diem PPS is the only achievable and rational first step in obtaining the cost savings needed in Medicare at this time. It is far preferable to challenge providers to achieve savings by efficient operation, and to reward them for doing so, than to simply cut payment rates. Implementing a per diem PPS now will enable the pricing of services for entire episodes of care or the refinement of capitated payments. I will have more to say later about this key priority.

- We cautiously **support consolidated billing for all SNF services to Part A patients** and are continuing internal discussions regarding consolidated billing to Medicare Part B patients. In addition to losing $400 million over the budget period, significant issues have not yet been addressed in any draft we have seen.

  We do not believe that HCFA or the Congress has fully explored the details or policy ramifications involved in exactly how such a system would work, and we encourage a thorough review of these issues with providers before the final legislative language is drafted.

In addition to these provisions directly affecting SNFs, we also wish to state our views on a few other proposals in the FY '98 Budget, including:

- We **oppose the provision redefining discharges from hospitals to PPS exempt entities** and feel this will incentivize acute care providers to hold on to patients longer to obtain the full Diagnostic Related Group (DRG) payment and then move patients into related, PPS exempt services.

The more appropriate solution to address the problems HCFA is concerned with is best summed up by Dr. Uwe Reinhart in a January 31, 1997 letter to AHCA's Executive Vice President Dr. Paul Willging, where he stated, ***"...what is needed is a recalibration of the DRGs to reflect the modern potential of subacute care, and then a system of open, competitive bids for Medicare's subacute care business, without any differential between hospitals and freestanding SNFs."*** At the very least, the Administration's justification of the provision to eliminate double dipping could be used limit the scope of the provision to facilities directly related to or controlled by the acute care referring organization.

- **A Medicare Respite Care provision could be potentially very helpful to a great many individual seniors and their families. Nursing facilities commonly offer respite care on a private-pay basis, and should be recognized as providers of any new program benefit for that service.** However, to be candid, we also wonder if a new and very limited benefit costing $1.8 billion is feasible at this time.

- We **oppose any provider service organization (PSO) provision that does not ensure a level playing field** for all providers and gives a competitive advantages to hospitals or physician networks.

- We **oppose the Administration's attempt to repeal many of last year's fraud and abuse provisions** including advisory opinions for providers, provider protections against unfair civil monetary penalty authority, and a provision prohibiting "intentional" transfers of wealth from wealthy individuals to qualify for Medicaid.

    ⇒ While the latter provision was poorly drafted, it should be repaired, not repealed. In addition, individuals wishing to transfer significant assets out of their estates should be required to purchase an appropriate amount of long term care insurance as a precondition to receipt of Medicaid-funded services in the future.

There are also several provisions in the Budget without cost implications which we would like to address. They include:

- We **support the extension and the expansion of the Program of All-inclusive Care for the Elderly (PACE) demonstration**, but believe critical improvements should be made in consultation with providers examining ways of expanding the program into the health care marketplace. The legislation should be expanded to allow new entities, including for-profit sponsors, to obtain certification as PACE providers after a trial period based on published conditions of participation. There is no justification to allow only non-profits or public entities to participate; to do so would be blatantly discriminatory and would impede access to the capital necessary to expand the benefits of this cost-effective integrated delivery model to older people throughout the nation.

- We **strongly support the Administration's Nurse Aide Training proposal** to ensure that training programs in rural areas are not jeopardized due to unrelated survey deficiencies. We encourage its immediate enactment and commend Senators Grassley and Conrad for introducing this legislation.

- We **oppose the imposition of new "user fees" for initial certifications under Medicare** for new facilities and continue to support the use of HCFA regulated accreditation organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), for SNF survey and certification. JCAHO is currently utilized for hospital certification, a much more complex facility than a nursing home, and using JCAHO for surveys under guidelines which are at least as stringent as HCFA's would save as much as $110 million per year.

- We **support the collection of data for HCFA to explore developing an integrated post acute care payment system.** However, we oppose granting the authority for the Secretary to implement any such system without Congressional oversight or approval. While we are the lower cost provider of post acute services and could benefit from such a system, preliminary research we have already undertaken shows the similarity of patients across sectors may not cover the entire spectrum of current post acute services.

These are our views on the Administration's budget provisions.

Let me also bring up four key points we would like to make sure you are aware of before you begin drafting reconciliation legislation.

First, we **are concerned over the level of reductions providers in general are being asked to contribute to shoring up the Medicare Trust Fund.** In the long term care field in particular, where 76% of our patients are funded by Medicaid (68%) or Medicare (8%), our ability to pass on these costs without a reduction in quality would be virtually impossible -- especially in conjunction with repeal of the Boren Amendment.

Second, we ask you **to recognize the difference between cost-based reimbursement systems and "profitable" acute care DRG systems when allocating industry specific reductions.** It is unfair for post acute care providers to be allocated similar spending reduction targets when our reimbursement system does not build in the significant profit margins which acute care providers currently are making.[1]

Third, post acute care has been somewhat unfairly singled out for "high rates of growth." Our **analysis of the causes of the growth show it has been largely stimulated by the hospital sector.** We have documented through HCFA data a 31% reduction in patient lengths of stay for the 62 most common subacute care DRGs during the time period ProPAC singled out for high post acute growth.[2] This movement of patients "quicker and sicker" into SNFs and home care has driven spending growth on post acute care services. While the increased population accounts for a third of this growth, the fact that patients are higher acuity, "sicker" patients require a higher level of spending on ancillary services and routine costs for patient needs.

However, until a patient classification system is finished, and applied to SNF patients, quantifying how much of an impact the higher acuity has on spending is difficult. We believe, nonetheless, that this factor is significant, and cannot be dismissed in assessing the reasons for spending growth.

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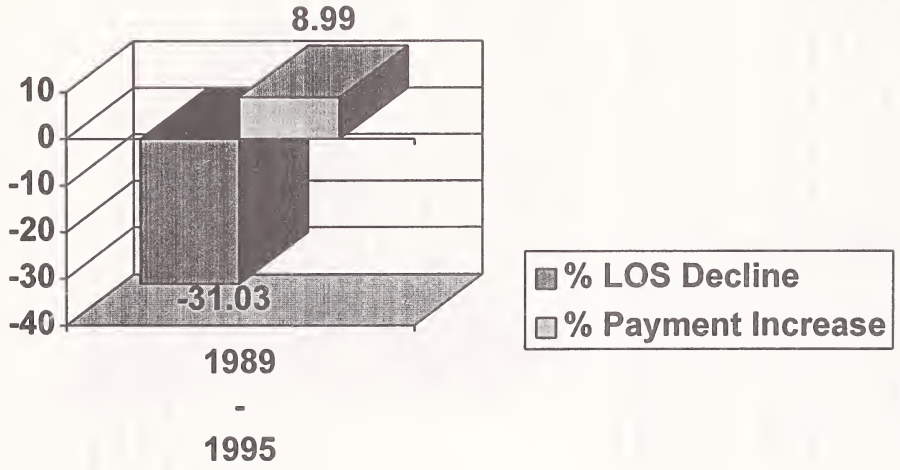
[1] The Prospective Payment Commission reports that the average PPS margin for all hospitals will increase to 13% by 1998.

[2] See attached chart developed through HCFA data published in the federal register.

62 Most Common Post Acute DRGs

Acute Payments and Length of Stay (LOS)

Source: Federal Register - HCFA Final Rule - 5/31/89 through 9/1/95



In addition, much of the growth in SNF post-acute services can be attributed to the hospital-based SNF sector, and little has been done to quantify this factor. Hospital-based SNFs have been growing at a 200% rate vs. a 29% for freestanding SNFs.[3] Hospitals now account for over 17% of SNFs and 22% of home health agencies. In 1994, they accounted for 13.3% of SNF facilities, and yet received 30% of Medicare SNF payments. Clearly the hospital-based sector has been driving much of the growth in post acute care.

Finally, the promise of post acute care was not only intended to be quality, lower cost rehabilitation, but to **achieve cost savings by substituting such care for more expensive acute care. While the substitution has taken place through the movement of patients into the lower cost setting, the hospital DRGs have not been adjusted accordingly. The Medicare program should benefit by sharing a portion of the efficiencies gained through the recalibration of the most common post acute care DRGs**. The 31% reduction in patient lengths of stay should have garnered savings for Medicare as well as for hospitals, and the availability of post acute care allowed that efficiency to take place.

In the coming weeks, we look forward to working with you and commenting on these issues further. Of critical importance to the industry is the design of the new PPS. Unlike the acute DRG system, HCFA seems to be headed for a much quicker, 4-year transition period. **It is critical that this new system, which will encompass all SNF reimbursement, be designed to ensure the PPS:**

- ⇒ Provides for an adequate case mix system covering the broad range of ancillary services (e.g. high cost drugs) being utilized and patient groups being treated in skilled nursing facilities (SNFs) and include an expanded case mix or outlier policy to cover high cost drug, therapy, aids or other intensive-need patients.
- ⇒ Bases the PPS rates on the latest available cost reports capturing the full range of a facilities case mix and acuity and incorporating transition language for new facilities or legitimate facility case mix changes in the base year.
- ⇒ Is designed to accommodate the development of a more complete patient classification system that can be used to move to an episodic PPS in the near future.
- ⇒ Continues the current PPS or expands the threshold for low-volume SNFs.
- ⇒ Protects providers and consumers from arbitrary action by HHS or HCFA to impose so-called normative length of stay standards or payment limits without Congressional or industry input.
- ⇒ Is scored after Congressional Budget Office "behavioral offsets" are reduced due the fact that all SNF services are being included in the PPS.

Mr. Chairman, and Members of the Committee, we ask that you consider one final request. We are being asked to tighten our belts again; to become more efficient and to work within new limitations to help shore up the Medicare program. This, we are glad to do, and wish to work closely with you in ensuring this effort is fruitful and will ensure the continuation of high quality patient care within our facilities.

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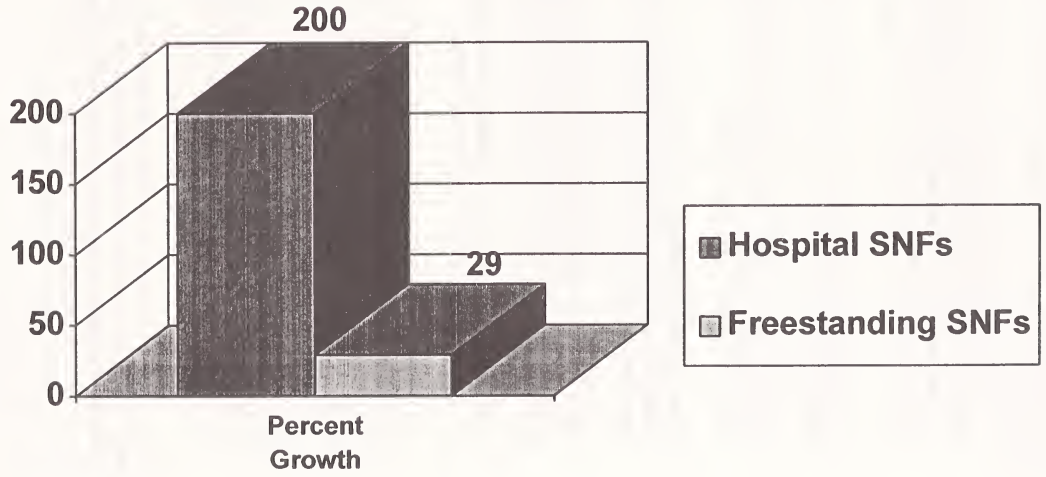
[3] See attached chart developed from the ProPAC 1996 Annual Report to Congress.

Growth in Hospital-based SNFs 1986 through 1994

Source: Prospective Payment Commission



We urge you to review legislative initiatives that would not only reduce spending on services within our facilities but which would improve efficiencies, quality or patient care. Some of these initiatives include legislation pending or which will be introduced shortly in the 105th Congress. Our concept is one of a free-market, level playing field for all providers, where quality and cost of patient care take precedence over the site where services are delivered. To this end, we wish to emphasize the following positions on key legislative issues before the Finance Committee:

- **THREE-DAY HOSPITAL STAY**: Support full repeal of the Medicare three-day hospital stay or at least legislation being proposed by Senator Dick Durbin (D-IL) and Congressman John Ensign (R-NV) to require Health and Human Services Secretary Donna Shalala to waive the three-day stay for a minimum of five DRGs she determines should result in cost savings to Medicare.

- **NEW PROVIDER EXEMPTION**: Eliminate the "new provider" exemption prospectively beginning July 1, 1998.

- **CONSOLIDATED BILLING**: Support required consolidated billing by SNFs for all services to Part A patients. Support voluntary consolidation by SNFs for Part B services with copies of all bills going to the facilities and/or family members.

- **TRANSFER AND DISCHARGE PROPOSAL:** Oppose the transfer and discharge proposal in the FY '98 Administration Budget or at a minimum apply the reduced per diem acute payment in cases where patients are transferred to related facilities.

- **REGULATORY REQUIREMENTS**: Require that regulatory or survey and certification requirements be applied to providers equally across the continuum, including deemed status through JCAHO accreditation and OBRA requirements for hospital based nursing facilities and employees.

- **WAIVER OF LIABILITY**: If the Medicare waiver of liability is reinstated for any group or provider, then it should be reinstated for all providers.

- **PROVIDER SPONSORED ORGANIZATIONS (PSOs):** Support PSO legislation as long as it allows nursing facilities to establish PSOs on a level playing field and accept risk as providers.

- **POST-ACUTE CARE BUNDLING:** Oppose any effort to bundle post-acute care services through hospitals or any one provider organization.

- **CONSUMER REFERRAL NOTIFICATION**: Support H.R. 734, legislation introduced by Congressman Pete Stark (D-CA) to require Hospitals wishing to transfer patients to related home health or SNF services to report such transfers to HCFA and notify consumers of other area options.

Thank you, Mr. Chairman, for inviting us to appear before you today. We look forward to working with you to see that a PPS for SNFs is implemented and that the post acute care continuum contributes to improving and shoring up the Medicare program in a fair and equitable manner.

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AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

INTRODUCTION

Mr. Chairman and Members of the Committee, I am Sheldon L. Goldberg, President of the American Association of Homes and Services for the Aging (AAHSA). I am grateful for the opportunity to submit testimony for the record of your hearing on the President's FY '98 budget proposals regarding Medicare post-acute care payment policies.

AAHSA represents not-for-profit organizations dedicated to providing high-quality health care, housing and services to the nation's elderly. Our membership consists of over 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community-based service organizations. With our broad range of facilities and services, AAHSA serves more than one million older persons daily. We have a long history and consequently, significant experience in meeting the needs of the elderly. We recognize the important role that the Medicare program has played in ensuring that the health care needs of older Americans are adequately met.

The future of the Medicare program will be affected by a rapidly growing population of the elderly and individuals with disabilities, diminishing resources in the Hospital Insurance Trust Fund, and growing costs of providing medical care. This future presents many difficult problems that this Congress must face, if the country is going to maintain its commitment to its seniors. We appreciate the competing and sometimes incompatible demands that you must reconcile in order to keep the Medicare program operating. We pledge to work with you in any way possible to control health care spending and reduce the national deficit while still preserving access to high quality skilled nursing, home health and other health care services for our nation's elderly.

Our members include not-for-profit home health agencies (HHAs) as well as skilled nursing facilities (SNFs) and my comments today generally apply to both types of providers, since many of the issues relating to prospective payment are similar. We will specify when referring to one type of service in particular.

LONG-RANGE VISION

Looking well into the future, we believe our members will be actively participating in managed care. They will be providing care and services financed by systems that coordinate care across time, place and provider. These systems will emphasize prevention, risk-sharing and appropriate utilization of services based on consumer and community demand for maximum health and well-being at lower overall cost.

We see the beginnings of these systems now, as evidenced by the growth of managed care and Medicare beneficiaries' growing participation in Health Maintenance Organizations (HMOs). There is a greater use of cost-effective, post-acute services and fewer days spent in expensive, acute care hospitals by managed care enrollees. Managed care organizations already receive substantial cost savings from the use of subacute care services without a three day prior hospital stay and from the substitution of post-acute care for unnecessary hospital days. Unfortunately, the Medicare program currently can not reap the same savings from these trends.

In particular, Provider Sponsored Organizations (PSOs) represent a potential opportunity for our members to demonstrate their expertise in managing the chronically ill population. The development of Provider Sponsored Organizations that permit affiliated providers to join in a risk sharing network should provide as many opportunities as possible for diverse participation by long term care providers. Qualified PSOs must offer the full range of Medicare primary, acute and skilled nursing services, and may offer additional benefits, including vision, hearing, and pharmacy services.

ADMINISTRATION'S MEDICARE BUDGET PROPOSALS

AAHSA recognizes the need to reform the Medicare program in order to prolong and preserve the solvency of the Part A Hospital Insurance Trust Fund. It is necessary for all involved with the program to contribute to that end, including beneficiaries and the government. We are concerned, however, with the disproportionate burden being shifted to the providers of care and services.

We understand that health care providers cannot continue with a "business as usual" attitude. It is also important for Congress and the Administration to recognize the additional major cutbacks proposed for the federal Medicaid program, additional Medicaid cuts in many states, and the growth of managed care. That means SNFs and HHAs will not have the flexibility to cross-subsidize unreimbursed costs for Medicare patients with revenue from private patients.

Expecting skilled nursing facilities to absorb more than $9 billion in budget cuts over the next 6 years and home health agencies, $18 billion, through the implementation of the Administration's budget proposals is just not realistic. Therefore, AAHSA proposes the following cost saving measures to help reduce the need for such drastic cuts:

- First, the elimination of the three day prior hospitalization requirement for selected diagnoses would permit the substitution of less expensive subacute care in SNFs and HHAs for the more costly acute hospital care.

- Second, the revision of acute hospital prospective payment rates, based on current lengths of stay, would permit Medicare to accrue savings from the substitution mentioned above and from the growing use of cost-effective subacute services instead of more expensive acute care days at the end of hospital stays.

PROSPECTIVE PAYMENT SYSTEMS for SNFs and HHAs

We recognize that reform of the current retrospective, cost-based reimbursement system is inevitable and that some form of prospective payment is likely. The current Medicare PPS for low-volume SNFs is a start that has been working fairly smoothly, but it is only a small, first step. A well designed PPS could promote management efficiencies and create some savings for the Medicare program. But a poorly designed PPS could mean unintended consequences that might harm the Medicare program, its beneficiaries, and the long-term care industry.

Our following comments about PPS are rather general because the Administration's legislative proposal includes relatively few details of how the system will actually work. That puts an excessive policy-making burden on the regulatory process rather than on the legislative process, which causes us concern.

We have seen from the implementation of the hospital PPS that the health care industry is very complex and can react in unexpected ways to PPS incentives. For example, the reduced hospital length of stay was an anticipated and desired result of PPS implementation. With hindsight, the growth of subacute care based in hospitals seems a natural result, but it was not as clearly expected at the time of implementation. Prior experience would argue for implementation of a PPS very gradually and with careful evaluation of its implementation and impacts.

GOALS: While the most immediate objective for initiating a prospective payment system (PPS) may be to produce program savings, it certainly is not the only one. Following are some other goals that ought to be included when designing a new reimbursement system.

- Access to care: The PPS should facilitate the timely movement of Medicare patients from acute care to the appropriate post-acute care setting. Reimbursements should not be set so low that providers would be reluctant to accept patients with high acuity, needing relatively intense or lengthy courses of treatment.

- High quality care: The PPS should reward high quality care and focus on quality outcomes.

- Efficient use of resources: The PPS should encourage efficiencies while recognizing that circumstances will vary from one provider to another. The choice of service setting or provider type as well as the specific mix of services to be offered should be encouraged to reflect the efficient use of resources as well as medical necessity and patient choice.

- Ease of administration: The current system of cost reporting with retroactive adjustments, audits, and settlement delays is cumbersome and costly. Management of the program by Medicare and of the service by the provider should be greatly streamlined.

- Innovation: Given the current dynamism of the health care market, the PPS should not lock-in the status quo, rather it should permit and encourage innovation and change. It should also recognize the costs of compliance with any new federal requirements, such as changes in the minimum wage or new OSHA or HCFA directives.

UNDERLYING ASSUMPTIONS: Basic to the achievement of these goals are some important underlying assumptions.

- Skilled nursing facilities must rehabilitate Medicare beneficiaries in their care to the highest practicable physical, mental, and psycho-social well-being. This is federally mandated by OBRA '87.

- In general, Medicare payment for nursing care and home health services should approximate the reasonable costs of efficient providers. It does not matter how finely constructed are the incentives of the PPS, if there is not a realistic level of funding in the system.

- There are some legitimate geographic and regional differences, such as labor market wages, and factors affecting provider costs that are to be expected.

- Not all costs of producing services can be controlled directly by management.

- The growing expenditures of the Medicare program, and post-acute services, particularly, result not only from the lack of a PPS. Growing expenditures result also from growing numbers of beneficiaries with greater needs for services, increasing medical needs of patients resulting from shorter lengths of stay in acute care hospitals, and improved treatments, new technologies, drugs and supplies.

ELEMENTS OF THE PROSPECTIVE PAYMENT SYSTEMS:

Case Mix Adjustment: Basic to the achievement of almost any of the goals mentioned above is the ability of the PPS to discriminate among patients requiring different levels and types of care and associating that with the resources used in treatment. In other words, residents or clients requiring more expensive and extensive courses of treatment should generate a payment amount greater than the average patient. Likewise, a relatively easy care patient should generate a payment less than the average. However, there should also be an incentive to rehabilitate the patient and move a high acuity patient to a higher functional level with a less intense level of service needed.

In the acute care hospital, prospective payment per case is set by diagnosis, but a classification by diagnosis for post-acute care is not a good predictor of resource use. Functional limitations are a better indicator of costs of care within a given post-acute care setting (SNF or HHA). Nonetheless, further refinements are needed to develop acuity adjusters that reflect the resources used in a day of SNF care or in treatment of an episode of care.

AAHSA is very concerned with the administrative mechanisms for linking the case mix of a SNF patient with the appropriate payment level. The MDS resident assessment is not completed instantly upon admission and, indeed, is not required for completion until the 14th day. Many subacute patients leave before it can be completed. If the prospective payment is dependent upon MDS data for determining the patient's acuity level, how will providers be paid for such cases as well as for the early days of any stay without adding enormous administrative burdens on the facility to speed up the MDS process? How quickly will HCFA develop an abbreviated MDS suitable for short-stay patients? Could initial acuity levels for payment purposes be determined from hospital discharge data or some other source?

A case mix adjuster for HHA patients is also far from full development, although the second phase of a demonstration project is in operation. There is not yet any case mix adjuster that explains a significant amount of the variation in costs per case or episode for post-acute care. It is essential that case mix adjusters for both HHAs and SNFs be developed, refined and tested as quickly as possible before a PPS is put into effect.

Unit of Payment: The most commonly mentioned units of payment are: episode/case/stay and per diem/visit. While it is relatively straightforward to define a visit or day for payment purposes, defining a post-acute case or episode of care or a SNF stay becomes more complex. Care of a Medicare beneficiary in a post-acute setting can be punctuated by an acute incident requiring temporary hospitalization and then a return to the same or a different SNF or HHA. Or, a resident may leave the SNF to return home, have a relapse or find it impossible to manage at home and then return to the SNF. Likewise, a HHA client might stop service for a period, either because of an acute or post-acute care admission or for lack of continuing need, but then return later to HHA care for the same diagnosis.

Defining and keeping track of a beneficiary's treatments during an episode of post-acute care requires very sophisticated and integrated information systems. Even with a clear definition of episode, it will be difficult determining norms for payment purposes. The appropriate, medically necessary post-acute care course of treatment can vary significantly, even for patients with the same diagnosis or functional level. In addition, the social and family supports and personal preferences of a beneficiary can affect the length of treatment and setting.

The choice of payment unit affects the incentives of the PPS. These incentives would need to be carefully balanced with an effective quality assurance and outcomes monitoring system. With a payment per episode there would be an incentive to reduce or eliminate unnecessary services. Similarly, it could provide an incentive for underservice or early discharge.

For home health, in which Medicare's concern is with an increasing proportion of cases receiving long courses of treatment with many visits, a payment per episode would be appropriate. However, such a mechanism to control volume

of services in the home health setting would need to be balanced by effective monitoring of quality and outcomes as indicated in the OASIS demonstration and a payment process for exceptional cases.

The choice of a unit of payment for SNFs is different and should be a per diem, as the administration has proposed. Acute hospitals have had a PPS based on episode for a dozen years. After observing the trend of those hospitals to discharge patients "quicker and sicker", we fear the risks of that method for SNFs. The incentive to discharge SNF patients more quickly could have a detrimental effect on beneficiaries as well as on Medicare payments to other acute- and post-acute care providers. There is no evidence of an increase in the average length of stay of Medicare skilled nursing patients or of dramatic increases in the proportion of beneficiaries using SNFs that would justify such an incentive. Medicare's concern with the growth in the number of therapies and ancillary services could be met with a per diem payment. In addition, the SNF Medicare benefit has a limit of 100 days and a copay of $95 per day after the 20th day (unlike the unlimited HHA benefit) which probably helps deter unnecessary utilization.

Covered Costs: Ultimately, the PPS should include all costs related to caring for Medicare beneficiaries: routine, capital and ancillary costs for a SNF and visit, travel, and administrative costs, etc. for a HHA. A comprehensive payment is more attractive administratively for the program and the provider, facilitates planning and permits flexibility of operations. However, an all-inclusive payment presumes a knowledge of all the components of care and associated costs that currently go into an episode or day of care and a norm of what volume of service ought to be included. That information and understanding is not yet available. Thus, a phased-in approach, perhaps covering only routine costs initially with other costs (capital and ancillaries passed through), until complete data are available would make more sense at the start of a PPS.

HCFA has a Multistate Skilled Nursing Facility Medicare Case-Mix Demonstration currently underway. Soon, HCFA should be receiving data from it on case mix adjusted payments for SNF care that includes some ancillary costs along with routine costs. However, the project is very limited in the number and geographic spread of participating facilities as well as limited in the costs covered. Related to this Case Mix Demonstration is a Staff Time Measurement Study designed to gather more data on resource use linked to patient acuity, with special emphasis on subacute care. Despite this extra study, that data are very limited for creating a nationwide case mix system including all SNF costs. The evaluation of the demonstration will not be available in the near future

Even with the case mix demonstrations, HCFA will not have complete data on all the ancillary services and supplies and their costs that are currently associated with particular categories of cases. It is of great concern how those costs will be appropriately built into base year calculations and associated with appropriate case mix levels. Treatment protocols and clinical pathways for common post-acute diagnoses are still under development. It will be difficult devising reasonable assumptions about numbers of HH visits and appropriate SNF ancillary costs to cover in an all-inclusive payment. This again would argue for a phased-in approach.

Consolidated Billing: The Administration's budget proposes to have nursing homes bill for all services a resident receives, other than services provided by a physician, certified nurse midwife, qualified psychologist, hospice and certified registered nurse anesthetist. Durable medical equipment and enteral feeding supplies are included. It appears that nursing facilities would be responsible for both Part A and Part B billing. Part B billing would be required even when the resident is not receiving Part A reimbursement.

We understand the need to include all bills related to a Part A stay to keep the PPS payment comprehensive and all-inclusive. In addition, we understand the possible benefits to Medicare in terms of reduced waste and fraud by suppliers, if the SNF also bills for Part B. However, we are extremely concerned about the administrative burdens placed on the facility and the need for HCFA to develop a workable system in conjunction with the industry. Most SNFs will need training and computer support to take over this function. Sufficient lead time also will be needed. The President's Budget would require implementation six months after the budget is passed or July 1, 1998, whichever is later. Neither date provides sufficient time. Also, there is no provision for reimbursing homes for the additional administrative costs, which are not reflected in the PPS base year.

Inflation Factor: Any PPS must recognize the impact of inflation on the provision of services. The "market basket" approach used for the Medicare low-volume SNF/PPS makes sense. However, the projections and updates should be made in a timely fashion to assure their accuracy and close proximity to reality, since a retroactive adjustment for inaccurate projections would be counter to the prospective philosophy. In addition, the cost basis for calculating the PPS rates must be rebased periodically in order for it to reflect current medical practices and costs.

Since the design of the PPS is predicated on the assumption of realistic levels of payments, it would be a gross distortion of the system to use the inflation factor as a mechanism for reducing the payment levels to meet arbitrary congressional or administration budget constraints. Arbitrarily abusing the inflation factor, as the Administration has proposed, in order to achieve budget savings targets shows a clear disregard for the goals of PPS and makes the industry leery of supporting any reimbursement change.

Other Adjustments: Geographic adjustments are important for recognizing variations in costs affected by place of service (urban/rural) and costs of labor in different markets. Such adjustments are included in the low-volume Medicare SNF/PPS and the hospital PPS system and appropriate mechanisms should be included in any new PPS system for both SNFs and HHAs.

Outliers: Even with a sophisticated, fully tested case mix system, there will be a need for recognizing exceptional cases requiring substantially more services than the norm. With a crude case mix system still under development and not fully tested, the exceptions process becomes even more important. This is particularly true with respect to home health, where the benefit is not time- or visit-limited.

Implementation Schedule: The administration's proposal to begin PPS for SNFs as early as July '98 and 1999 for HHAs seems overly optimistic given the inadequacies of the essential data bases and methodologies. AAHSA recommends another year to develop each system and then a slow phase-in. This is especially important for building SNF capacity to do consolidated billing, also. Each PPS should be phased-in gradually over at least six years to permit smooth implementation and the avoidance of drastic and inappropriate changes. The Administration's proposal requires full implementation of SNF PPS by the fourth year, which is too fast; a six-year phase-in would be more appropriate.

Site Differentials: In keeping with the goal of matching the payment amount to the acuity of the case and level of services needed, AAHSA recognizes the need to eliminate the differential payment for hospital-based SNFs and HHAs. It is important to create a level playing field for free-standing and hospital based providers.

Waiver of Liability: This item is missing from the administration's budget proposal, but should be added. Given the complexity of Medicare's eligibility rules and definitions, providers of SNF and HHA services need the reinstatement of the waiver of liability, whether the payment system is retroactive or prospective. This is necessary to protect innocent, careful providers who unintentionally and on rare occasion, make a coverage mistake and to ensure the timely availability of services to all beneficiaries.

OTHER BUDGET PROPOSALS

Post-Acute Care Integrated Payment System: The Prospective Payment Assessment Commission (ProPAC) has recommended the bundling of acute and post-acute services into a single payment for the episode of care. Superficially, the proposal to bundle payment for all post-acute services with the prospective payment to the acute care hospital may seem to promote the efficient substitution of care in cost effective settings and program savings. However, in reality, it would create distortions in the marketplace and would shift control of patients back to the hospital. Much of post-acute care, particularly for the chronically ill, would suffer from the over-medicalization of the treatment model. Also, hospitals would have an incentive to retain relatively lower cost patients in their own nursing units and to discharge relatively higher cost patients to free-standing facilities, but their incentives concerning payments would be to retain more money to cover their own higher cost nursing units and to contract with free-standing facilities at reduced rates. The trend towards integrated delivery systems, combining primary, acute, post-acute and long-term care providers with case management and equitable sharing of risk, has a greater potential to improve the quality of care delivered to beneficiaries and to produce savings. This is mainly because there would be less bias towards the most expensive providers.

The administration's budget proposal does not go as far as ProPAC's; it focuses on bundling only post-acute services. As is clear from the earlier discussion of PPSs for home health and skilled nursing facilities, there is a long way to go in

perfecting case mix and other adjustments for those systems. The development of a totally "site-neutral", case-mix adjusted, episodic payment system predicated upon a standard core patient assessment instrument belongs in the 21st century or beyond. One can not debate the merits of such a concept now, without any details. The health care world will look substantially different by the time HCFA has the capability of designing any such system and the concept may no longer be relevant. Certainly it is premature to grant the Secretary blanket authority now to develop and implement such a payment system through regulation at some future date. Whenever the Secretary has details of a realistic system to propose, it should be done through the legislative process with congressional oversight and adequate public participation. In the meanwhile, AAHSA supports authority only for the Secretary to collect data necessary for analyses of related issues. We do offer the caveat, however, that SNFs are still in the process of computerizing the MDS and that any additional reporting burdens on providers be weighed very carefully before any new data collection efforts are started

Centers of Excellence: AAHSA is opposed to the expansion of this program to include such procedures as hip and knee replacement and to include post-acute services in the single rate because the acute care hospital often does not have the necessary gerontological skills to manage Medicare patients needing extensive post-acute care, rehabilitation and support services beyond the medical model. The previous discussion of the current impossibility of case mix adjustments to account for the related costs of an episode of care in just one setting (a SNF or HHA) make this proposal seem even more farfetched. Given those inadequacies, it is not realistic to expand this purchasing program. Certainly such a program should undergo careful scrutiny and evaluation before substantial expansion.

Purchasing Through Global Payments: Tne Admilnistration proposes a competitive contracting process with hospitals or other entities for services related to specific medical conditions. Payment would be based on negotiated or all-inclusive rates. The contracting entity may offer incentives to beneficiaries to enroll and may require lock-in for the services provided. Is this some new form of managed care, disease-specific PSO, or what? What organizational structures, quality controls, etc. are intended?

AAHSA members are uniquely prepared to focus on the continuum of needs of the chronically ill and they recognize the cost-effectiveness of high quality preventive care and supportive services in maintaining the elderly in the least restrictive setting. Ideally, however, such integrated care should be comprehensive and focussed on the whole individual, not just on a particular diagnosis, since the elderly frequently have co-morbidities and functional limitations. A truly effective chronic care program would not necessarily produce cost savings within 30 days and we question the value of such an approach with only a 30-day lock-in.

AAHSA is supportive of measures to encourage innovative approaches on a demonstration basis, but is opposed to open-ended provisions, such as the Global Payments proposal, especially since it could mean a bundled payment for acute and post-acute care with control going to the hospital.

Definition of Transfer and Discharge: We understand the Administration's proposal to redefine certain hospital discharges to be considered transfers, that the hospital's payment would change, but there would be no changes for the receiving post-acute care provider. AAHSA is opposed to the redefinition of transfer and discharge from an acute hospital to any post-acute care setting. Such a change would make it relatively advantageous for acute hospitals to hold on to their patients longer than may necessary. Again, Medicare needs to revise the length of stay assumptions on which DRG payments are based, in order to benefit from the true savings of the post-acute care providers, who treat subacute patients at a lower cost than do acute care hospitals.

User Fees: AAHSA is opposed to Medicare's imposition of user fees charged to providers of Medicare services and services for the dually eligible for initial certification. However, AAHSA recognizes that HCFA's resources for survey and certification are insufficient to accomplish its current responsibilities without changes to the process. AAHSA supports legislation to allow for deeming of nursing facilities through a national private-sector agency as an option under Medicaid as well as Medicare.

PACE and SHMOs: AAHSA supports the shift of demonstration sites in the Program of All-inclusive Care for the Elderly (PACE) into full provider status because the model has proven to be a cost-effective way to provide integrated care to the frail elderly. In addition, new providers that meet the PACE standards should be given permanent provider status. The extension of the Social Health Maintenance Organizations demonstrations is warranted to allow a full evaluation of this service delivery model.

Home Health Shift from Part A to B: AAHSA supports the transfer of some home health care coverage from Part A to Part B, recognizing that, in itself, this will not reduce total HHA expenditures. However, such an interfund transfer can make a significant contribution to prolonging the solvency of the Part A Trust Fund. AAHSA emphasizes the importance of the Administration's accompanying language which will ensure that the beneficiary bears no additional costs resulting from this transfer of HHA benefits.

Payment for Home Health Services Based on Location Where Service is Provided: AAHSA supports the administration's proposal that home health payment be determined from the site where the service is actually furnished – the patient's home rather than the HHA's home office and wants that proposal to be very clear.

Respite Benefit: AAHSA applauds the administration's recognition of the crucial role played by the family and other caregivers in supporting the elderly with chronic health problems and disabilities. We realize that budget constraints dictate a very small benefit. Respite care for beneficiaries suffering from dementias is a reasonable place to start. The $7.50 per hour payment limit does not seem at all realistic, given the level of care often needed by such patients.

The greatest need for relief often hits those caring for beneficiaries who are totally homebound, totally dependent and needing a round-the-clock

presence of a caregiver. To provide real relief to the caregivers, a brief escape from their heavy burdens, and to permit them to carry on for longer periods on their own, it may be necessary to offer a brief and temporary stay in a SNF. Including SNFs as respite providers could prove cost-effective in the long run by delaying or preventing eventual admission of the dementia patient to a SNF for long-term care

CONCLUSION

We recognize the need to move forward with new and improved payment systems to cover Medicare SNF and HHA patients. Well designed and implemented Prospective Payment Systems for all SNFs and HHAs could meet many of the needs of the program as well as of providers and beneficiaries. We are concerned, however, about imposing too rapidly any system that has been inadequately tested and is based on insufficient data. In addition, the Administration's initial level of payment reductions, ($9 billion from SNFs and $18 billion from HHAs over 6 years), are excessive, unnecessarily high and threaten the provider's ability to deliver high quality care. Any additional budget cuts imposed on Medicare providers would be totally unreasonable.

In conclusion, we recommend:

- The three-day prior hospitalization requirement be eliminated for selected diagnoses;
- The PPS payments to acute care hospitals be revised to reflect more accurately current lengths of stay;
- The Waiver of Liability be reinstated;
- The collection of necessary cost and utilization data and the evaluations of the case mix demonstrations as quickly as possible;
- The refinement of quality assurance systems based on outcomes monitoring to protect against negative impacts on patients of payment system changes and reductions;
- The gradual implementation of PPSs only after the development of complete data sets that are needed, fair and equitable methodologies are tested, and reasonable payment levels are set;
- Monitoring of program implementation to spot potential problems early. Monitoring should include evaluation of the implementation phases and their impact on the health care industry broadly and on SNF and HHA providers, beneficiaries and their quality of care and the quality of life, in addition to their impact on Medicare's budget. Changes and revision of the PPSs should be expected based on the evaluation.

We look forward to working with you in the months ahead to help develop a payment system that will work for Medicare, its beneficiaries, and the whole post-acute care industry. Thank you for this opportunity to present the views of the not-for-profit nursing facilities and home health agencies who are members of the American Association of Homes and Services for the Aging.

STATEMENT OF THE AMERICAN REHABILITATION ASSOCIATION
SUBMITTED TO COMMITTEE ON FINANCE
UNITED STATES SENATE
April 9, 1997

Mr. Chairman:

This statement is submitted on behalf of the American Rehabilitation Association and addresses the need for reform of the present system under which the Medicare program pays for services rendered to its beneficiaries by rehabilitation hospitals and units.

The American Rehabilitation Association (formerly the National Association of Rehabilitation Facilities) is the largest not-for-profit organization serving vocational, residential and medical rehabilitation providers in the United States. Our membership includes about 300 rehabilitation hospitals and units. My testimony addresses the need for a prospective payment system for such facilities.

The objective of medical rehabilitation is to eliminate or mitigate disability. We seek to restore a person's ability to live, work and enjoy life after an illness, trauma, stroke or similar event has impaired his or her physical or mental abilities. Most patients enter rehabilitation after an acute hospital stay. About 450,000 people per year receive such services as inpatients in rehabilitation hospitals or rehabilitation units of general hospitals. Many more receive such services as outpatients. There are now about 200 rehabilitation hospitals and 860 rehabilitation units in general hospitals recognized by the Medicare program.

Many of the conditions requiring rehabilitation services are associated with advancing age, particularly strokes, arthritis and orthopedic conditions. Accordingly, a relatively high percentage of the persons who need rehabilitation are covered by Medicare. In 1995 about 72% of discharges from rehabilitation hospitals and units and 67% of total days of care were covered by the Medicare program. These figures do not include Medicare beneficiaries who have chosen to enroll in managed care plans. Thus, rehabilitation facilities are perhaps more affected by Medicare policy than any other element of health care.

I. THE CURRENT PAYMENT SYSTEM SHOULD BE REFORMED

Rehabilitation hospitals and units are excluded from the Medicare PPS and are paid for services to Medicare patients on the basis of reasonable cost, subject to per-discharge ceilings imposed under TEFRA. TEFRA limits were imposed in 1983 as a temporary measure. They distort the delivery and cost of hospital rehabilitation services in a number of ways:

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* TEFRA limits do not adjust for change in case mix and/or increased acuity of patients. This means that completely legitimate increases in intensity of services or length of stay will push a provider's costs over its limit.

* TEFRA limits place pressure on rehabilitation hospitals and units to cut average length of stay as a means of reducing per-discharge cost. By treating all rehabilitation discharges as having the same value, the system provides a strong incentive to treat short stay, less complex cases and avoid more severely disabled patients.

* New hospitals and units can establish limits based on contemporary wage levels and other costs, thereby achieving much higher limits than older hospitals. Hence, hospitals in the same service area may have widely differing TEFRA limits and reimbursement for similar services. This has led to enormous growth in rehabilitation providers. Medicare is paying the bill.

* This system inhibits the development of new programs for severely disabled patients by existing providers, because any change in services that increases average length of stay or intensity of services will likely result in costs over a TEFRA limit. Meanwhile the Medicare program encourages the development of new rehabilitation hospitals and units. This adds unnecessary cost while eroding the service capacity of established institutions.

* The administrative process for adjustment of TEFRA limits does not provide a remedy because it does not produce timely decisions and does not recognize many legitimate costs.

* Because HCFA routinely allows new providers much higher limits than older ones, the construction of new hospitals and creation of new units is encouraged. There are about four times as many rehabilitation hospitals and three times as many units now than when TEFRA limits were introduced. Large incentive payments are being paid to new hospitals while many older facilities lose money on Medicare patients because of much lower TEFRA limits.

II. THE MEANS EXIST TO REPLACE TEFRA WITH A PROSPECTIVE PAYMENT SYSTEM FOR REHABILITATION PROVIDERS

While some providers are helped and others hurt by this system, no one (including HCFA) defends it. Its replacement with a rehabilitation prospective payment system (RPPS) has been recommended by ProPAC repeatedly and the Trustees of the Health Insurance Trust Fund.

In 1990 the Congress directed HCFA to submit recommendations for reform by April 1992. Nothing has been forthcoming. To try to fill this void rehabilitation providers funded research to design a patient classification system to serve as the basis for a PPS for rehabilitation. This work was done at the University of Pennsylvania and was highly productive. There now exists a system of patient classification groups that include almost all Medicare patients. These classifications, known as functional related groups (FRGs), predict the duration and intensity of rehabilitation services based on a patient's age, diagnosis and functional abilities on admission.

In the fall of 1995 HCFA awarded a contract to the RAND Corporation to evaluate this system and, if it was found to be suitable, to design a prospective payment system for inpatient rehabilitation. This work is substantially complete. RAND has reported to HCFA that FRGs are a sound means of predicting resource use and has developed a complete set of recommendations with respect to case weights, outliers, treatment of transfer cases and other components of a rehabilitation PPS. It follows the structure of the acute PPS, substituting FRGs for the DRGs. Since it had a much larger database than did the original researchers in 1990, it refined and expanded the system to 82 FRGs. The final RAND report which is due at the end of this month will include the results of simulations of the system, and recommendations to assure that quality is maintained and any perverse incentives are eliminated or mitigated.

All that is needed is legislation to implement it. We are not talking about pie in the sky, but rather a technically sound system designed for HCFA that can be introduced with modest lead time.

Adoption of a payment system whereby hospitals are paid based on the types of patients they treat is needed. It would eliminate the incentive in the present system to develop new hospitals and units (adding ever more cost) and compensate all providers based on services provided rather than the completely arbitrary and inequitable TEFRA system. Most importantly, a PPS for rehabilitation would eliminate the most perverse aspect of the present system--the explicit message to hospitals to avoid severely disabled patients. The Congress never envisioned such an effect when TEFRA was adopted as a temporary measure.

A PPS for rehabilitation, even if budget-neutral upon adoption, would result in considerable savings to the Medicare program by eliminating the strong bias in favor of new providers. In the short term some providers of services would receive less in Medicare payments as the inequities of the present system are rectified. But, payments based on patient need can only serve the legitimate interests of both hospitals and patients - and the government - over the longer term.

Legislation has been introduced in the House to authorize PPS for rehabilitation facilities, based on the payment system developed by RAND. The text is suitable and is commended to the Committee. It is H.R. 585 the Rehabilitation Hospitals and Units Medicare Payment Equity Act

of 1997.

III. THE PRESIDENT'S MEDICARE PROPOSALS WOULD NOT FIX THE FLAWS OF THE TEFRA SYSTEM

Unfortunately, the President's proposals for Medicare reform do not include a PPS for rehabilitation, although prospective payment systems are proposed SNFs and HHAs. The Administration would continue the thoroughly discredited TEFRA system, albeit with adjustments. This is essentially an endorsement of present payment policy, for which no affirmative defense is (or can be) offered. TEFRA has failed to control costs and has distorted patient care in the process. In its 1996 Annual Report ProPAC reported sharply higher payments for rehabilitation and long term hospitals. This was found to have occurred largely because of the TEFRA system which, ProPAC noted, "encourages the development of new facilities and rewards those that have high costs." In its 1997 report ProPAC was stronger on this point. It recommends a case-mix adjusted prospective payment system for rehabilitation hospitals and distinct-part units should be implemented as soon as possible. It stated "Because the work to develop a prospective payment system based on FIM-FRGs should be completed soon and the system has strong support from the rehabilitation industry, implementation in the near term is feasible."

The President's proposals would continue the incentive under TEFRA for providers to avoid severely disabled patients. This flaw will continue until a prospective payment system which adjusts payments for case mix is adopted.

The Administration's proposal for tinkering with TEFRA are discussed below. They are a mixed bag. Their worst feature is the illusion that they cure the flaws of present law, without doing so. They would not provide for adjustment of payment to case mix. Only a PPS will do that, but enactment of them would likely be taken as having "fixed" TEFRA and thereby eliminate the need for a PPS, a very unfortunate outcome. An analysis of the components of the President's proposals based on documents received to date and discussions follows, without having the final documents or language,:

* **Rebasing of TEFRA Limits.** The Administration would rebase TEFRA facilities using an average of FYs 1992 and 1993. While rebasing has the superficial appeal of making all equal by adopting recent cost as the basis for future limits, in fact rebasing would perpetuate the inequities of the past. It would lock into new TEFRA limits the discriminatory effects of old ones while doing nothing about the obvious need for a payment system that reflects case mix. Were these interim measures tied to a date for implementation of a PPS they would be more suitable. However, enactment of these proposals would likely be used to rationalize further delay on a PPS and thereby do more harm than good. The Budget proposes to keep TEFRA through at least 2002.

* **Elimination of Incentive Payments.** If TEFRA limits are rebased there should be an incentive to reduce cost per discharge under new limits. Rebasing would eliminate incentive payments relative to old limits. There is no reason to eliminate them with respect to new ones.

* **Floors and Ceilings on Limits.** No TEFRA limit would be less than 70% of the national average (for the appropriate type of provider) and adjusted for regional wage variations. This is a good idea, if done as an interim measure. A ceiling of 150% would be applied as well. As temporary expedients these actions might mitigate the effects of the TEFRA system, but without a case mix adjustment factor, they have no fundamental logic.

* **Updates.** An update of TEFRA limits at market basket minus 1.5% has the effect of continuing to encourage providers to admit and treat low cost patients and avoid more disabled and complex cases. Without adjustment of payments for case mix, lowering limits inevitably has this effect. This proposal again makes the case for a PPS so that payments are scaled to patient need and the efforts of smaller updates apply evenly to all facilities and patients.

* **Reduce Capital Payments.** The Budget proposes to reduce capital payments by 15%. Without a PPS, in which capital cost would be subsumed, this proposal is quite arbitrary. Most new facilities, the creation of which was induced or aided by the TEFRA system, have much higher capital cost than older ones. They would still receive much higher payments.

* **OBRA 93 Variable Updates.** The provision of variable updates, depending on whether a hospital or unit's costs are over or under its limit, is a sound idea. Under OBRA '93 facilities with limits 110% or more over their limits received the full market basket for TEFRA facilities as the update. Facilities under their limits receive the market basket minus 1%. This authority was enacted for FYs 1993 -1997. It would be eliminated under the Administration's proposals. If rebasing produces less variance from limits it may have limited effect immediately after rebasing, but over time TEFRA limits will inevitably become obsolete. This authority should be retained to protect facilities over their limits.

* **Adjustments.** The President would largely eliminate administrative adjustment of TEFRA limits. This makes no sense, particularly when coupled with the use of TEFRA well into the future. Since there is no case mix adjuster in the system it is essential that recourse to administrative adjustments continue.

* **OBRA 90 Cost Sharing.** This provision would largely be eliminated by having it apply only to cost more than 10% above a limit. Since most cost over limits is in this band the effect of this change would be to largely eliminate the source of relief. The present system should be retained.

*** Redefinition of "Transfer".** The Budget contains a proposal for reducing certain PPS payments for acute hospital services when a patient is moved to a rehabilitation provider. This is accomplished by defining such a move as a transfer rather than a discharge and admission. This change would provide an incentive to retain patients in acute beds longer, rather than initiating rehabilitation in a timely manner or sending them home when it may be inappropriate. It also would destroy the concept of averaging, an essential ingredient of the DRG system, by reducing payments on stays below the average, but not increasing them for stays over the average. ProPAC has recommended against any such policy. It should be rejected.

*** Authority for a Comprehensive Post-Acute Prospective Payment System.** The Administration proposes that HCFA be given statutory authority to implement a comprehensive PPS for all post-acute services (rehabilitation, SNF, HHA, long term care hospitals). Apparently, the adoption of any such system would not, under any circumstance, be during the five-year period for which projections are made in this Budget proposal. This means that the adverse effect of the TEFRA system will continue past FY 2002. Unless the Congress enacts a PPS for rehab, a "temporary" measure to control costs pending a PPS will last at least 20 years!

Does the notion of a comprehensive payment system for post-acute services make sense? Perhaps in the long run. Does it make sense to continue a flawed system in the meantime, when a better alternative is available? Absolutely not.

Prospective payment schemes are proposed for SNFS and HHAs, when the methodologies for these types of providers are less developed and discrete than that fashioned by RAND for rehabilitation patients. If PPSs for these providers do not prejudice the movement to an ultimately unified payment system for post acute service, neither does one for rehabilitation. The stated goals of such a system are to recognize the relative costs of treating different kinds of patients and to avoid incentives to treat patients in one venue or another, depending on payment. These goals can be achieved for rehabilitation by implementation of the RAND payment system for rehab. If, and as, HCFA perfects an alternate or complementary system, a RPPS can be modified accordingly or integrated into it. It is hard to imagine a comprehensive case-mix adjusted system that is incompatible with the weightings produced by the FRG system. Thus, early implementation of a PPS for rehab based on the RAND report will further, not retard, the longer term goal.

IV. BUNDLING REHABILITATION INTO THE DRG PAYMENTS IS A POOR IDEA

From time to time, it has been suggested, most recently by a CBO report "Medicare Spending on Post-Acute Care Services: A Preliminary Analysis" that rehabilitation services should be "bundled" into DRG payments. ProPAC has recommended that a demonstration of this idea be started. This is not a good idea, or at least the mechanics are sufficiently difficult as to defeat the principle.

It is assumed that "bundling" means increasing a DRG payment and making the DRG provider responsible for rehabilitation and other post-acute services. Presently the DRG payment covers only the acute stay, and the provider of rehabilitation is paid separately.

The main reason to oppose bundling is its potentially adverse effects on patient care.

Acute care medicine is addressed to the immediate medical condition of patients. It focuses on the pathology and chemistry of a given diagnosis. Rehabilitation is concerned with the patient's ability to function--to perform the daily activities of living, working and otherwise enjoying life. For example, in the acute phase, a physician attending a stroke patient is concerned with reducing cranial swelling and the potential for another stroke through drug therapy. Rehabilitation of the patient would center on restoring or improving his or her ability to walk, talk, use his or her arms and legs and adapt to any residual limitations of these functions. This is done through the interdisciplinary provision of physical, occupational, speech and other therapies, as well as psychological counseling to deal with the depression that often accompanies newly experienced physical disability. Rehabilitation also involves working with families and others who are affected by the patient's condition and whose response is likely to affect the patient's progress.

Good medical practice calls for the coordination of these different types of services, but in concept and philosophy they are quite different.

The fundamental problem with bundling rehab into DRGs is that it creates a conflict of interest for acute providers, who will have a strong financial incentive to deny or abridge rehabilitation services. About 860 hospitals have rehabilitation units, but most do not. There are over 5,000 hospitals in the country. The incentive to give short shrift to rehabilitation is particularly telling in the case of a hospital that must refer the patient to another provider for services. Thus, bundling would likely reduce the availability of rehabilitation services and/or encourage the creation of more rehabilitation units, duplicating capacity that now exists.

Further, to my knowledge there is no basis for computing the amounts by which DRGs should be increased for rehab (and/or other post acute services). Such costs vary widely depending on the patient's diagnosis, age, degree of impairment, family circumstances, medical condition and other factors. As noted, a patient classification system for rehabilitation patients has been developed and we hope it will serve as the basis for a PPS. It does not, however, tie to DRGs. Rather, its primary element is the functional status of a patient upon admission to rehabilitation. Thus, any bundling of rehabilitation into DRGs would be extremely arbitrary and therefore harmful to patients.

Finally, there is no current system to monitor whether care is appropriately provided under such a system; in other words, to measure outcomes. Rehabilitation providers are unique

in the health care system in that they focus on outcomes--the improved functional capabilities of their patients. A decline in utilization of their services, which would inevitably accompany bundling, would result in a loss of such focus and higher levels of residual impairment and dependency. It would also likely result in higher acute medical costs as patients do not regain function and independence.

For these reasons we believe that bundling rehabilitation into DRGs is a very poor idea.

V. CONCLUSION

The actions taken by this Committee and this Congress with respect to the Medicare program will have profound effects on persons who have or acquire disabling conditions. The actions we recommend will preserve and enhance the availability of rehabilitation services to Medicare beneficiaries while eliminating wasteful and inequitable practices under current law and provide for longer term budgetary savings.

Statement of
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Submitted to the
Senate
Committee on Finance

pertaining to the
April 9, 1997
hearing on Post-Acute Care Payment Policies Under Medicare

Mr. Chairman and members of the Committee, on behalf of Home Care Association of America (HCAA), I am pleased to have the opportunity to share our views concerning the critical issues related to Medicare payment policies for post-acute care services, especially home health care. I would like to begin by commending Chairman Roth for convening this hearing to address the critical need to control the rate of growth in Medicare spending, while assuring that necessary services will be provided to the most vulnerable members of our society, our nation's elderly. HCAA applauds and embraces these attainable goals. HCAA represents the voice of 400 freestanding home care agencies.

This submittal is divided into four sections: Section I - What This Committee Can Do Now; Section II - Our Response to commonly asked questions; Section III - A Comparison of HCAA's "Per-Visit" PPS Plan to "Per-Episode"; and Section IV - Other Issue.

Before beginning, HCAA would like to clarify that the "Revised Unified PPS (Home Care) Plan" presented to the Congress **does not have the endorsement** of the only two national associations exclusively representing freestanding agencies; nor does it have the endorsement of our respective state chapters. Noticeably absent from their "Declaration of Support" are the signatures of both HCAA and the American Federation of Home Health Agencies, AFHHA (AFHHA, similar to HCAA, is the other national trade association representing an equally large number of freestanding agencies.). HCAA would like to be included, as a witness, in future meetings/hearings on home health care. We are concerned that, although freestanding agencies represent the largest group of providers, the list of "home health care" witnesses (excluding the AHA) testifying before the Health Subcommittee of the House Ways and Means Committee consisted of two VNAs and one chain--there was no home health care representation by freestanding proprietaries. While we support the right of other associations to have their voices heard, HCAA is compelled to ensure fair representation of our members' values and beliefs and of the rights of their patients. We believe that fair representation is also necessary in order for the goals of this Subcommittee to be effectively accomplished.

SECTION I - WHAT THE COMMITTEE CAN DO NOW

(a) Stop Fraud and Abuse Enforcement---How? Have Industry (Preferably AHCA and HCAA) Representatives on ORT task force and place limits on ORT over-zealous surveyors.

(b) Stop Improper Hospital "Double-Dipping" (Once in their DRG "charge" based rates and then again in their SNF and Home Care "cost" based rates). --- How? By eliminating the allowablity of Hospitals Administrative & General cost allocations to their Hospital-Owned SNFs and Home Care Facilities.

(c) Stop Inappropriate Hospital "Self-Referrals" --- How? By requiring HCFA to enforce 42CFR 424.22 against Hospital-Owned agencies who are violating the Law.

(d) Stop Unjust Cost Caps (that currently propose home care skilled nursing and home health aide Cost Cap Limitations, for all agencies nationwide, at levels BELOW Pre-Freeze levels). ---How? Instruct HCFA that when such a condition exists, Cost Caps must be made equal to Freeze levels.

SECTION II - ANSWERS TO COMMONLY ASKED QUESTIONS

(a) Fraud and Abuse Enforcement- ORT & Need For Industry Input

No one industry organization has shown more concern over fraud and abuse in home care than HCAA. In fact, HCAA's Chairman, Dwight Cenac, delivered a scathing report to HCFA on November 11, 1992 pinpointing abusive activities by both ABC (a $600-million, 400-office chain operation) and other mega agencies utilizing subcontracted staff at greatly inflated prices. In a subsequent telephone follow-up, Mr. Cenac queried HCFA's Mr. Eric Yospe, a HCFA official bearing some responsibility for the audits of home care expenditures nationwide, on dealing with these abusive issues, and provided him additional information on how a major abuser of subcontract services in Miami, Florida (Hospital Staffing Services, Inc. (HSS), a $90-million, multi-office chain) was improperly milking the Medicare program millions each month. For the most part, the activities reported by Mr. Cenac were discarded by HCFA--although, MUCH LATER, a great deal has been said to Congress about these activities; and no credit has been afforded to the freestanding agencies for our attempts to help police such mega felons. In fact, years before the OIG prosecuted these felons, HCFA's Yospe stated, in response to the allegations of impropriety raised by Mr. Cenac, that HCFA had no way of ascertaining the fair value of subcontracted services; and that there was nothing wrong with HSS 's exclusive utilization of subcontracted nurses--even after he was informed by Mr. Cenac that such subcontracts were from separate corporation(s) *OWNED* by the referring physicians. What is greatly troubling to HCAA is HCFA's and the OIG's misrepresentations that freestanding proprietaries (who generally bill less than $10 million annually) are, somehow, similar to these mega chains and self-referring physician practices; and, somehow, should be subjected to increased scrutiny--now under the umbrella of ORT--because of such felons. HCAA is not opposed to investigations of fraud and abuse. In fact, as stated above, HCAA has attempted to bring such issues of fraud and abuse into light--**years before they were brought to Congress, or for that matter, before the felons caught.** What HCAA is opposed to, however, are two issues: first, the unwarranted singling out of freestanding agencies--while, at the same time, the unwarranted selective exclusion of HMOs, hospital-owned agencies and chains from ORT's process; and second, the improper use of excessive force by ORT's inexperienced and overzealous surveyors aimed at expelling freestanding agencies from Medicare participation by improperly interpreting **guidelines that they are NOT similarly and simultaneously applying against hospitals and chains**. It is in this **spirit of fair play** that HCAA appeals to this Subcommittee (1) to properly and uniformly channel the ORT task force; and (2) to request the incorporation of valid industry input, such as HCAA, into the selection and investigation of today's sophisticated health care thief. Although **Peg Cushman** testified on behalf of NAHC and the home care industry, she later told HCAA that NAHC's legal counsel, **Mr. Bill Dombi**, failed to notify her of the ORT abuse hearing he attended on behalf of NAHC member CSM (a freestanding agency in California). HCAA was concerned regarding the failure, in the testimony given, to reference the real atrocities occurring against the freestanding agencies under the umbrella of ORT. CSM Home Health Services, Inc., is a 10-year-old Los Angeles agency, which has spent more than $60,000 on legal and consulting services to fight its improper Medicare decertification after an ORT survey.

One independent home care news reporter stated that the CSM story is not new--in fact, "In California, 26 of 40 planned surveys were completed last month. voluntarily withdrew from the Medicare program; and one filed for bankruptcy. Think that because you're not in one of Operation Restore Trust's five targeted states, you'll escape its increased scrutiny? Think again. The latest state to be snared by the fraud initiative is Tennessee." **The presiding judge over the CSM case, the Honorable John G. Davies (Case No. CV 96-4651-JGD),United States District Court -Central District of California, could find no legal grounds (this is precisely why this Subcommittee's intervention is needed) to grant CSM relief, although he definitely wanted to. Judge Davies said of the ORT process, "I think the surveyors -- I think CSM Home Services has a case. The evidence that is before me that I have perused, read, considered, leads me to those conclusions. The Surveyors, I had the Impression, were not reticent to wear their power on their cuff and to manifest it and exercise it in ways that are undesirable in today's society. The bureaucracy overreacted once again. That is my view of this case. But, what relief can I give you?"**
What follows is a portion of the sworn testimony of one of CSM's key employees. It is given this Subcommittee as a reference point of the type of agency being abused by the unbridled ORT process, as it currently operates. "I, Jean R. Murphy, R.N., have been a registered nurse for over twenty years, a portion of which was served as an officer and flight nurse in the United State Air Force. I have approximately thirteen years of experience in home health care as an administrator and/or consultant. I am currently administrator of CSM Home Health Services, Inc. I have held this position for four years. CSM has been serving Los Angeles' underserved minority communities since 1985. These communities include the Rampart District, South Central Los Angeles, Koreatown and other primarily minority communities. ***CSM's clerical and field staff are also primarily minority. CSM staff continued to serve their clients during the 1992 riots under security guards. During the Northridge earthquake, my staff forsook their families to rush to the aid of their patients. One black certified home health aide was present in a board and care facility during the earthquake; and placed several residents under mattresses to protect them as she, herself, braced and quieted their fears. The CSM Director of Nurses stood in water without power using her cellular phone to try to reach staff and patients to ensure their safety, despite the fact that she, herself, was in peril because the gas supply in her apartment had not been turned off and had been evacuated for fear of explosion. One of CSM's clinical supervisors was carjacked and robbed at gunpoint while she sat in her car solving a patient crisis on her mobile phone. Another registered nurse, whose husband had driven her to a patient's home after the riots, was shot as they sped away to avoid being carjacked or killed. CSM has undergone Medicare recertification surveys annually since its founding. These surveys have been conducted by the surveyors from the Department of Health Services, who have found only minor deficiencies with CSM's compliance with Medicare Conditions of Participation. CSM responded to these deficiencies with corrective action plans; and there have never been any termination actions initiated against CSM as a result of these minor deficiencies."***

HCAA asks the question: Does the Committee believe that CSM is the type of agency at which ORT should be targeted?

For the record, below is a sampling of the ORT findings used against CSM, as the basis for booting CSM out of Medicare (None of the findings were related to patient care--odd isn't it?):

G104 - Standard: Exercise of Rights and Respect for Property and Person. The surveyors alleged first that there was a conflict between CSM's admission consent form and CSM's patients right form. CSM believes that it was in full compliance with this standard at the time of the survey, since the general consent form simply authorizes the agency to begin treatment; and the patient rights form gives the patient the right to refuse any specific treatment at any time. However, CSM amended both of these forms to comply with the surveyors' expectations. The Surveyors also alleged that CSM had deficiencies in informing patients of the State home health hotline number, because some of the patients could not explain to the surveyors the purpose of the hotline. However, the regulation requires only that the hotline information be provided to the patients in writing. Upon admission, CSM provided (verbally and in writing) all of the information regarding the hotline number to each of the surveyed patients.

G108 - Standard: Right to be Informed and Participate. The surveyors alleged that CSM was not in compliance with this standard because one patient claimed that he was not informed of his patient rights and was not included in the plan of care. However, CSM had documentation that this patients had signed a patient's rights statement; and, therefore, was informed of his rights.
Surveyors also alleged that one patient was told by a physician that he wanted the patient to be referred to CSM. CSM did not condone or request this action by the physician; and, therefore (I believe) cannot be held responsible for the physician's actions. Further, this alleged problem does not appear to be covered by this regulation; and, therefore, CSM was not out of compliance with this Standard.

Other issues cited by the ORT surveyors were similar AND were not patient care issues

HCAA is not alone in its concerns and observations regarding the need to oversee such ORT policies. *Testimony given by Susan Bailis, AHCA, states that the Subcommittee should "carefully monitor the implementation of the 1995 Survey, Certification and Enforcement rules to ensure they are cost-effective, and are not abused by over-zealous inspectors and are enforced fairly and evenly."*

The final comparison I would like to make, to what is happening in the ORT process, was best stated by Ann Chadwell, Knight-Tribune News Service. Ann states that, *"Behavior that is high-handed and harsh from people in control toward people economically beholden and unable to fight back is cheap."* Ann shared a story to make her point: "There's a great story about passengers mobbing the reservation counter after a cancelled flight. Airline personnel were doing their best to rebook passengers quickly. A demanding passenger pushed to the front of the line, pounded on the counter and shouted repeatedly, ' You have to get me on this plane.' The reservationist remained accommodating and unrattled. The passenger's tirade became even more incensed and insulting. 'Do you know who you're talking to?' he shouted. 'do you know who I am?' The reservationist calmly took the microphone and announced over the intercom, 'We have a passenger who doesn't know who he is. Will someone who knows this passenger please come identify him?' That caused the other passengers to erupt in applause." **This fine example was given to me by my thirteen-year-old son, Dwight Cenac II.** I believe that **America would cheer** a Subcommittee which properly brought back into-line an out-of-order bureaucracy which has lost touch with the issues.

(b) Hospital "Double-Dipping" - Overcharging Medicare Billions (for HHA and & SNF Covered Services)

Recently during a hearing in the House Ways and Means Committee, one committee member repeatedly asked the NAHC and PPS Work Group home care representatives about the impact of hospital "double-dipping" and self -referrals (See section (c), below, for our separate concerns on self-referrals.) upon the home health care industry and upon their PPS "per-episode" proposal. I believe most agencies would be shocked to hear that the only response given was by Mr. Hoffman (one of the two spokespersons for the PPS work group), who stated, "I have never given it any thought." This is a most incredible response, given the massive amount of adverse publicity this activity has received in Texas (Mr. Hoffman's state of residence). HCAA does not concur with such unreliable testimony. Today's flawed reimbursement to hospital-owned agencies (and SNFs) essentially allows hospitals to commit legalized fraud/abuse by "double dipping" Medicare funds. Today, hospitals are rapidly jumping into home health care and unethically blocking referrals to freestanding agencies because they've discovered a reimbursement loop-hole that allows hospitals to get paid twice. They are able to do this **once** with their Medicare DRG rate, which includes their administrative costs, **and then** by allocating this very same administrative cost to their hospital-owned agency. In fact, hospitals are even purchasing agencies whose owners have been convicted of fraud (such as Health Masters). Hospital Medicare reimbursement needs to be changed to stop hospital administrative "double-dipping," falsely called "cost shifting." A "cost shift" means just that! It means **shifting** a cost **to another location**.

It does not mean "**duplicating**" the cost somewhere else! Patients were supposed to be guaranteed a choice of health care providers! HCAA findings can best be compared to the testimony given by Susan S. Bailis, representing 11,000 freestanding SNF's who are members of the American Health Care Association (AHCA). Ms. Bailis shared in her testimony (again before the House Ways and Means Committee) the need to stop rewarding inefficient hospitals through Medicare's failure to recelebrate DRG's (improperly allowing hospitals to double-dip Medicare in the SNF market as well). HCAA shares Ms. Bailis's concerns about HCFA's unwarranted "desire to continue to subsidize less-efficient and more-costly hospital-based care." Identical to HCAA's concerns, Ms Bailis testified as to "incentives for hospitals to allocate labor, administrative, and general costs over to PPS-exempt SNF units (one Executive identified $50,000 per bed as a common figure); and the ability of hospitals to receive a cost-based payment higher than a freestanding SNF, in addition to the full DRG payment,". AHCA proposed, and HCAA agrees, that hospital "DRGs be examined and recalibrates according to severity of illness and length of stay." Although most experts (including testimony by Ms. Bailis and testimony by Joseph P. Newhouse Ph.D., Chairman of ProPAC) agree that the recalibration of DRGs is needed, they seem to be at a loss with regard to how to get it done. HCAA proposes, therefore, that the only other appropriate interim solution is to simply STOP the hospital's double-dip allocation (to Medicare), of its administrative costs (already included in its charge-based DRG), to cost-reimbursed home health care or SNF care rendered in facilities owned by the hospitals. HCAA has calculated that Medicare could save $1.2 Billion annually (in the home health care market, alone) by stopping this double dip. AHCA calculates that Medicare could save "$9 Billion per year (in the SNF market)!"

(c) Improper Hospital Self-Referrals

Again, HCAA is concerned over the lack of response, given by the "so-called" home health care representatives who have testified before Congress in the past, who do not inform Members of Congress about unethical self-referral tactics by hospitals. In this age of the "free-market", Medicare Patients should have the right to freely CHOOSE their Medicare Provider. The issue of self-referrals should be of keen interest to this Committee for the following four key reasons:

(1) Self-referrals cost Medicare significantly more.

The Congress has already received testimony to the effect that home care, provided by hospitals, costs more. Evidential testimony was given to this effect by HCFA, ProPAC, AHCA (similar SNF substantive testimony), and even the AHA which (unbelievably) petitioned to keep such overcharges legal.

(2) Self-referrals create inappropriate market dominance and deny patient choice.

The best response was made by AHCA, which testified before Congress that such inappropriate rules are "directly attacking our ability to compete in the sub-acute Medicare marketplace."

(3) Self-referrals (from physicians) have already been legislated as Non-Allowable (But HCFA refuses to enforce this Regulation when it applies to hospitals.).

Unfortunately, HCFA has blatantly refused to **enforce** 42 CFR 424.22 in a even-handed manner against hospitals which violate this significant policy. Specifically, 42 CFR 424.22 prohibits Medicare (HCFA) from paying claims to hospitals (and all other home health care agency types as well) for any home care referrals received from physicians compensated more than $25,000 annually.

(4) Self-referrals create overutilization (and hence costs) of home care services .

Surprisingly, no one testified before the Congress on ProPAC's finding of hospital overutilization of home care services WHEN they own the home care agency they self-refer to. **The June 1, 1996 "Report To Congress" submitted by Joseph P. Newhouse, who testified before the House Ways and Means Subcommittee on Health, stated that, "Hospital-based providers also were likelier than free-standing ones to treat beneficiaries who had been in the hospital."**

The vital issue of abusive hospital self-referrals is not as prominent in SNFs as it is in home care. We believe this is so because patients are normally familiar with the differences between a freestanding SNF and the hospital's; whereas such familiarity is not known for home health care. The primary reason that self-referrals is such a critical issue in home health care is because hospitalized elderly patients are victimized, by hospital staffers, into believing: first, that the hospital is the only provider; and second, that only the hospital-owned agency is capable of giving them the specialized care they need once they are discharged to their homesetting. The issue compounds itself because hospitals are purchasing physician practices and then mandating the physicians to self-refer to the hospital's owned agency. This "purchased" physician self-referral practice is **supposed to result in denial of claims**, based upon 42 CFR 424.22. Enforcement of 42 CFR 424.22 clearly falls into the jurisdiction of HCFA as it is a claim-denial issue, not a fraud issue--**and on June 18, 1996, the OIG brought this to HCFA's attention!** Specifically, the Chief Counsel to the Inspector General, D. McCarry Thornton, "copied" HCFA's Thomas E. Hoyer stating, "HCFA has the responsibility for enforcement of these regulations." *Eli's Home Health Care Report* stated that after the Thornton letter, HCFA itself will not issue further clarification on the issue. "They're going to adhere to their current interpretation (meaning hospitals are not permitted to self-refer) and their current 'enforcement' (which means no enforcement of the Law against hospitals), one source says." Another, notes that "*HCFA will now let the courts decide* the extent to which 42 CFR should be enforced (even though HCFA has made NO disallowances against violating hospitals) and whether or not hospital-based agencies should be granted a moratorium, as they have requested. 'Whether HCFA is going to do anything more than it has in the past, such as disallowing these claims, I don't know,' adds Pyles." HCAA has asked for a meeting with HCFA's chief, Dr. Bruce Vladeck, who testified before the Subcommittee, to uncover the truth as to why his office will not enforce 42 CFR 424.22 in an even-handed manner. However, Vladeck privately told HCAA that he **will not meet on this matter. HCAA feels it is imperative that this Committee require HCFA to even-handedly enforce the regulation (42 CFR 424.22) against violating hospitals; and then, if necessary, let the courts decide. To be fair to the hospital industry, HCAA would request that the Committee require HCFA to first, and immediately, instruct its Contractors and Intermediaries to notify hospitals about this potential liability; and then, make disallowances for referrals from physicians whom they compensate, directly or indirectly, over $25,000 per year.** HCAA wishes the Committee to know that this vital issue (self-referral) is not one evolving from the interest of hospitals in patient care, as there were few hospitals rendering home health care before DRGs. **The issue is clearly one created by the hospital's ability to be paid twice (see (b), above, on the "double-dip") and to get paid "twice as much" by (improperly) monopolizing referrals.** Specifically, there are two well- known industry suits recently filed (in Texas) against Columbia/HCA on the very issue of hospital improper self-referrals. One suit is a "whistle-blower" action filed by Dr. James Thompson, a family practitioner in Corpus Christi, Texas, contending, according to a November 11, 1995 Associated Press story, that "Columbia-HCA Healthcare Corp., the nation's biggest hospital chain, paid doctors illegal kickbacks (including cash, free vacations and cheap office rentals) in exchange for patient referrals". The second is a class-action suit filed on January 17, 1996, again, against Columbia-HCA, by a freestanding proprietary agency (CHS of El Paso,Inc - El Paso, Texas) alleging that Columbia-HCA owns four hospitals in El Paso and is employing monopolistic practices by having "pressured physicians with staff privileges" and "profit incentives" if they'll stop referring patients to CHS companies.

These instances of impropriety are far from alone. Some further examples of such hostile self-referral hospital tactics are recounted here as quoted form the June 3,1996 issue of *Eli's Home Health Care Report*: *" 'As we continue to see more hospitals get involved in the home health side of the business, outside the confinement of the hospital, our referrals continue to dry up,'* notes Glen H. Beussink, Executive Director of Cape Girardeau, MO-based home care provider Health Data Services, Inc. Marilyn LeVasseur, MS, RN, Administrator of Family Nurse Care in Brighton, MI, also says that her revenues have been hurt by a local hospital's getting into home care business. *' In April of this year, the only hospital in the county became affiliated with a multi-hospital organization, and our referrals decreased 30 percent,'* LeVasseur says. According to Beussink, *'many of the physicians are pressured ever so slightly to use the hospital services. '* The American Federation of Home Health Agencies (AFHHA) also notes that *'we have received many reports that physicians have refused to sign home care orders unless the patient agrees to use the hospital-based home health agency.'* The National Home Infusion Association (NHIA) agrees, noting that *'our organization routinely receives calls from both outpatient providers and physicians indicating that hospitals are increasingly pressuring physicians and patients, both directly and indirectly, to utilize the hospitals' own services. '* Phyllis W. Fredland, RN, Director of Nursing for Health Personnel Incorporated in McKee's Rocks, PA, also observes that *'here in Pittsburgh, if doctors refer to another entity outside the hospital, the hospital can revoke their privileges. 'In our area, they are nothing less than predatory.'* According to Robert J. Brock, vice-president of At Home Health Care in Redwood City, CA, *hospitals 'discard literature we deliver to the hospital."* HCAA uncovered another contemptible tactic used effectively by hospitals to prey on their medical staff employees. In a misleading letter to home care agencies in its California community, Scripps Memorial Hospitals, in San Diego, California, stated, "It is the intention of Scripps to give to our patients reasonable choice in their selection of healthcare providers." The real truth of its intentions is shown, however, in its February 16, 1996 secretive internal memo written to its Medical Staff (as a basis for restricting freestanding home care agencies from receiving referrals). It read, "We believe it is critically important to keep patients within the Scripps health system whenever possible. This enables Scripps to deliver its premier quality care while assuring continuity of patient care throughout the system. When patients leave the system and are enrolled in other home care agencies, we lose jobs for Scripps employees, dollars for the Scripps system, and risk adverse patient outcomes as a result of care that may be less than the Scripps standard." Caught red-handed in its deceit, Script gave this arrogant, and yet weak, defense for its actions: alleging that, somehow, **care given by others is not up to its premier standards (forget Medicare's)**; "patients are encouraged to use Scripps' facilities because the recommending personnel have first-hand knowledge of the quality of those services."

SECTION III - A COMPARISON OF PPS PLANS

(A COMPARISON OF THE PPS "PER-VISIT" PLAN TO THE "PER-EPISODE")

WHY A "PER-VISIT" PPS PLAN <u>WILL</u> WORK

ANY PROSPECTIVE PAYMENT (PPS) PLAN SHOULD GUARANTEE FIVE THINGS:

1. **That we pay for what patients receive (Not for what they don't)**. There should be incentives to provide needed care, not incentives to deny it when our elderly need it most.
2. **That the Government has the opportunity to share in savings.**
3. **That Medicare expenditures are "truly" contained.**
4. **That Medicare fraud/abuses are curtailed.**
5. **That a Medicare Review Program is in place to ensure quality care is being given.**

HCAA'S PPS "PER VISIT" PLAN GUARANTEES SAVINGS AND QUALITY CARE:

At the very core of HCAA's proposed PPS Plan, is our guarantee to provide care to the nation's elderly at an agreed-upon national cap for home care expenditures; thereby, controlling cost increases, and realizing a savings for the Medicare program. Let's not repeat the **tragic premature implementation of PPS** in home health care that occurred in 1983 for hospitals, by implementing an untested "per-episode" DRG PPS plan, resulting in today's four-fold cost increase. HCAA proposes a PPS plan that is based on per-visit (thus, guaranteeing the incentive is on **providing** care, **not** on **denying** care). Our plan also promised the opportunity for the government to share in savings (unlike a per-episode method wherein the payment becomes the ceiling and the government is thereby denied any opportunity for savings). **To guarantee that the rate of growth for home care Medicare expenditures is truly contained, HCAA proposes that there be a national cap on home care expenditures, adjusted only for two factors**: First, an annual cost of living increase; and Second, an annual adjustment based on the actual percentage growth in the beneficiary population. HCAA's "per visit" plan calls for a payment method that is both fair (eliminates the inducements to self-refer) and offers providers incentives and abilities to self-police, and expose today's sophisticated health care abusers. Congress has already received testimony that a flat, "per-episode" pay rate (similar to HMOs/DRGs) does not have the controls and safeguards in place to ensure necessary care is given, whereas HCAA's "per-visit" reimbursement rate, based on care actually provided, already has a quality assurance program in place within the current Medicare Intermediary system.

HOW TO IMPLEMENT HCAA'S PPS "PER-VISIT" PLAN:

* *HCAAs Plan is the Only Plan With a Fail-Safe National Cap:*

Statistics are readily available for current home care expenditures nationally, by state, and by local geographic area. HCAA proposes that these be used to establish a fail-safe cap and that this would be the only manageable basis to truly establish the control on the growth in Medicare expenditures. This fail-safe national cap would be modified only for the two adjustments described above: one, a cost of living increase; and two, beneficiary growth. For management purposes, the fail-safe national cap is to be further divided by state, and then by area. To manage (and curtail) fraud/abuse HCAA recommends that, FOR THE FIRST TIME, agencies be given authority to appoint representatives to monitor monthly area claim expenditures made by intermediaries, thus forming a "WE" team between government and providers. Abuses and unnecessary services can be more readily monitored by including the providers in the enforcement process. In the event of demographic population changes, an adjustment could be made between these smaller, manageable components - without altering the national cap.

* *HCAAs Plan is based on a "Per-Visit" PPS Rate - Thus Guaranteeing Care ("Per-Visit" is similar to the "Per-Diem" method HCFA endorses for the SNF industry)*

The current visit rates are already known. A geographic phase-in can be made, similar to the DRG phase-in with the exception that a mileage factor be included, in addition to a labor factor. Additionally, to stop hospital inducements to deny patient choice, payments to hospitals need to be "lowered" to reflect administrative costs already covered in their existing hospital DRG inpatient rates. Also, three further restrictions are necessary: First, a hospital cannot be entitled to receive more than 30 percent of its own referrals and should be prohibited from receiving referrals from other community sources. Second, there can be no more than a minimal amount of independent contractors for nursing or aide services (we recommend a 10 percent ceiling on such contracts). Third, physicians may not participate in home care remunerations. There is only one exception the "sole" community provider. Also, during the phase-in period, agencies must be permitted to market their services in the community, similar to the marketing used by HMOs and other health care providers in their area (with, of course, cost caps remaining during the phase-in).

WHY A "PER-EPISODE" PPS PLAN WILL FAIL

Any PPS method based on a "Per-Episode" payment will not succeed in either reducing current Medicare costs or insuring that care is provided to the elderly. Why? Here are the reasons:

1. **"HCFA SAYS "Per-Episode" Payment is a Bad Choice**.

   On page 20 of Bruce Vladeck's July 23 testimony, he hammers out why a per-episode payment is a poor choice as a PPS plan for SNFs. His same reasoning (on page 14 of his testimony) is exactly applicable to home care; and makes one wonder why he would even consider a per-episode PPS plan for home care, except that he stated that his plan for home care would not begin to transition to PPS until 1999 (at which time more data *could* be available on case-mix adjusters, etc). Mr. Vladeck stated, ***"There is no comparable information for per-episode prospective payment system. Not only do we not have sufficient information to determine the appropriate level of payment, no research has been conducted on the effects of a per-episode payment system on patient outcomes, quality, or access to care. The incentive under a per- episode prospective payment system could be for facilities to discharge patients as quickly as possible, as facilities receive the same payment irrespective of how many days the beneficiary remains in the SNF. Earlier discharge may result in poor quality care and increased overall program costs, as beneficiaries still needing services may return to the hospital or initiate home health visits. Furthermore, in the absence of an accurate case-mix adjuster (which currently does not exist to predict per-episode costs), SNFs would have an incentive to avoid more resource-intensive patients; and access to SNF care for the beneficiaries that need it the most would be reduced."*** Every reason given here by Mr. Vladeck is identical to the problems in implementing a per-episode payment for home care.

2. **"Per-Episode" Payment** is, by definition, a flat payment based upon characterization (similar to DRGs and/or HMOs).

3. **Overwhelming evidence** shows that a PPS "Per-Episode" method will fail to:

   A. Reduce Costs
   (Both DRGs and HMOs have not saved one cent. In fact, they have proven to cost more.)

   B. Provide care
   (Both DRGs and HMOs have proven to deny care).

4. **"Per-Episode"** will result in payment for what patients don't get--not a wise decision!

5. **Caution** - ***Adopt A PPS Plan That Pays Per-Visit, Not Per-Episode***

   The most important issue that everyone agrees on is that the rate of growth of health care "costs" should be controlled; but no one feels that "services" should be denied. HCAA implores you to reject the imposition of any PPS plan for home health care, such as per-episode payment, which is based on denying care and has no true cost control measures inherent in its design! As two bipartisan members of the subcommittee pointed out in the hearing, a per-episode method has the same inherent payment problems of HMO and hospital DRGs: denial of care and failure to control costs. It was also pointed out by the honorable Chairman that although the industry representatives testifying may like the per-episode method, there is no proof that it is a better method of controlling costs. Allow the current PPS demonstration project to be completed for home care; and consider the results. Seek home care industry input from freestanding proprietaries before PPS is implemented.

BEN FRANKLIN'S ACID TEST RESULTS

Equal a Decided NO to PPS Per-Episode and YES to PPS Per-Visit

Ben Franklin's method was to list the advantages and disadvantages in order to reach a proper decision.

THE ACID TEST	PER-VISIT (with a National Cap)	PER-EPISODE
1. Does it pay for what patients receive?	YES	NO
2. Will the government share in savings?	YES	NO
3. Will Medicare expenditures be contained as a result?	YES	NO
4. Will Medicare fraud/abuse be curtailed?	YES	NO
5. Is a medical review program in place to ensure quality care?	YES	NO

SECTION IV - OTHER ISSUE

1. STOP HMOs FROM OVERBILLING MEDICARE BILLIONS!

HCAA recommends HMO legislation to save the desired 6 percent (over $16 billion) in Medicare dollars annually, by requiring HMO Medicare reimbursements to incorporate a "case-mix" capitation adjustment. Currently, HMOs are paid an average of $4,500 per Medicare beneficiary, which was falsely computed based upon the naive assumption that HMOs would enroll a case-mix of both healthy and sick Medicare beneficiaries. Because it has now been proven that HMOs target the healthy elderly, and because these healthy enrollees cost Medicare less than $500 a year (Consumers' Research, 7/95), HMOs are costing (not saving) Medicare the billions of dollars that, alone, would keep the program solvent. For example, a "case-mix" capitation adjustment factor (i.e., payment of only $500 for healthy elderly enrollees, versus the current $4,500), would guarantee that HMOs would be paid only what it costs to provide quality care, plus a fair reimbursement for administration and profit. On Nov. 11, 1995, the GAO delivered its fourth HMO report to Congress with this statement, fully supporting HCAA's conclusion: "HMO Rate-Setting Methodology Thwarts Medicare's Efforts to Realize Savings." In fact, an NBC News expose documented that a full 90 percent of all Medicare beneficiaries cost an average of only $1,900 per year under traditional Medicare. HMOs currently overcharge Medicare $16 BILLION Annually.

Statement of the
National Association for the Support of Long Term Care
submitted to
The Senate Finance Committee
April 9, 1997

Mr. Chairman,

As members of The National Association for the Support of Long Term Care (NASL), we appreciate the opportunity to submit a statement for inclusion in the record of the April 9, 1997 hearing entitled "Medicare Payment Policies for Post-Acute Care." This statement will focus primarily on support for reforms in payment for skilled nursing facility services that will adequately pay for the care and treatment of seniors.

NASL is the only national organization that concentrates exclusively on legislation and regulatory matters regarding the provision of professional medical services and supplies to beneficiaries in post-acute care settings. NASL supports the option that the skilled nursing facility has to contract for medical services when they are needed. The authority to provide services "under agreement" or "under arrangement" gets Medicare savings as services are purchased only when a patient needs the medical care.

We support:

- for transitioning to a prospective payment system under Part A for skilled nursing services,
- for reforms which require billing Part A for Part A services, and,
- for eliminating artificial legal barriers to services for nursing home residents, such as transfer agreements and three-day stay requirements.

NASL has recently endorsed a **nine point plan for implementing realistic skilled nursing facility payment reforms**. The following is an overview of the approach which we are recommending to Congress and the Administration.

We urge the Congress and the Department of Health and Human Services to pursue payment reforms which achieve the following goals:

- enhance quality and improve beneficiary services,
- assure beneficiary access to appropriate services,
- improve accountability,
- reduce the rate of growth of Medicare SNF expenditures,
- protect against inappropriate utilization, and,
- institute reforms that can be implemented.

Applying these principles, NASL recommends the following:

#1: Transition to a SNF Part A Prospective Payment System:

NASL supports a transition to a Part A SNF prospective payment system. We urge the legislation be explicit in directing the Secretary to design the program to (a) reflect legitimate differences in cost differences between patients, (b) encourage appropriate access to medically necessary services, (c) encourage the provision of high quality medical care, (d) provide incentives for improving the efficiency in delivering services, and (e) base decisions on timely, accurate and relevant data.

The disruption of beneficiary services can be minimized through a realistic implementation of a prospective payment system. Steps can be taken in the coming year to transition existing routine services to a prospective system using an appropriate patient acuity classification system. It will take additional time to develop appropriate classification measures for ancillary services, thus, the inclusion of these medical services should be phased in separately from the schedule for basic nursing services. Likewise, payment for capital should also be phased in when appropriate measures are defined. Better data coupled with a transition from facility specific to national rates should be included in the PPS reform. Implementing these steps over a five year period is rational policy.

#2: Inclusion and Appropriate Classification of Part A Services:

The standard package of SNF services varies widely based upon patient needs, program size, and location. Though skilled nursing facilities offer a relatively defined set of routine services, most also offer a menu of diverse ancillary medical services. Facilities with a number of high acuity patients have high ancillary costs because these patients are in greater need of medical care services; facilities that focus on basic nursing services have relatively low ancillary costs.

NASL supports billing for standard SNF Part A covered services through the skilled nursing facility. Such an approach ensures an accurate accounting of all costs during that stay when in the design of the prospective payment system. It further ensures beneficiaries will receive a single bill for such services during the Part A stay. Senior citizens should receive routine and ancillary services when they need them. Implementation will require a recalculation of base year costs and an adjustment in the market basket to reflect the additional Part A costs that are currently billed to Part B.

We do not support the consolidation of payment for Part B services that follow the Part A stay. Consolidation should not be taken to this extreme. It will penalize facilities that have been innovative in meeting community needs. We urge policymakers to distinguish between those services which are standard within SNF delivery and those occasional or atypical covered services which some SNFs provide. Few SNFs specialize in treating

burn patients, AIDS patients, pediatric patients, ventilator dependent patients, spinal cord and head injured patients -- but some do. These innovative programs will not be economically sustainable if program costs are averaged or consolidated into the payment across all facilities.

#3: Simplified Rules for Low-Volume Facilities:

Reforms need to balance the twin goals of community availability and service efficiency. Program data underscores that fewer than a third of participating facilities account for 90% of Medicare SNF days and Part A costs. A complex SNF prospective payment requirement should not be imposed on facilities with an average daily census of 10 or fewer Medicare patients. Complexity will drive many low-volume providers out of Medicare thereby leaving beneficiaries unable to secure services. Rural and medically underserved communities will be penalized. Congress should extend and update the existing provisions for low-volume facilities and exempt them from the new PPS system.

#4: Implement Measures for Clinical Effectiveness and Delivery Outcomes:

There is a need to re-establish patient care as a priority. Post acute providers are subjected to reams of rules and regulations, scores of surveyors and overseers, and mountains of paperwork. Has anyone ever asked does it make a difference in patient caring?

There are many innovative approaches for care management that are currently used in the private sector. These tools should be put into place for public sector programs. There is an important shifting of managerial focus from input measures to output measures; i.e., measuring whether services are clinically effective and improve delivery outcomes, Medicare, the largest purchaser of health services, is behind in developing similar care standards.

A decade ago, the Congress pressed the Secretary to develop and implement standardized patient assessment tools. Today, that information is the basic building block for care planning. NASL believes that Congress should direct the Secretary to develop and test measures for clinical outcomes that improve patient care.

#5: Controls on Inappropriate Utilization:

Program abuses infringe upon the integrity of all providers and suppliers. Most caregivers are diligent, conscientious and professional. Some are not. Enforcement of clear and concise rules is essential to remove from our system those providers who intentionally commit fraud in the health care system.

The current system of oversight is a dismal failure. Rules are vague, interpretations varied and personal preferences have replaced professional judgments. Increasingly, we are witnessing carriers and intermediaries setting new rules. They redefine coverage and payment without notice and impose new standards that restrict the coverage of seniors. Authorizing the Secretary to work with provider, suppliers, and professionals in developing statistically verifiable normative standards for utilization, and linking those standards to measures of clinical effectiveness and delivery outcomes will both overcome the inadequacies of the current non-system and improve data on episodes of care. We recommend that Congress restrict the authority for determinations on inherent reasonableness to HCFA that will reduce the potential of unfair and unjust actions by intermediaries and carriers and replace it with a process that is fair.

#6: Improved Accountability for Part B Services and Supplies:

SNF volume of admissions and discharges fluctuates, patient needs vary, and there are significant differences between Part A lengths of stay and total length of stay in a facility. Under current nursing home requirements, facilities have the obligations to oversee the provision of all services to all residents, but payment rules permit facilities to secure services through in-house programs, "under arrangement," or "under agreement." Most SNFs received their specialty medical services through "under arrangement" and "under agreement" contracts.

Concerns have been raised as to whether there is adequate oversight of "under agreement" contracts to verify the care and its costs. These concerns can be realistically addressed by requiring facility/supplier contracts for Part B delivered services, and requiring access to contractor records. Such an approach does not disrupt service options for the facility and meets the oversight needs. NASL members do support increased accountability by all providers in ensuring services are provided that are medically necessary. Nursing home providers should work with providers or suppliers of services in ensuring services are provided and the documentation is maintained. Physicians should also be required to provide the adequate documentation, including diagnosis when required, to ensure the service is medically necessary. This important collaboration among providers and suppliers should work to ensure that nursing home patients receive the most appropriate medical care.

The members of NASL oppose the consolidation of billing for Part B services through the SNF except for those standard SNF services delivered during the Part A stay.

The reasons that NASL opposes consolidated billing for Part B services are:

1. The additional administrative burden and fiscal impact;
2. No documentation of unresolved problems with current billing practices;
3. Loss of access to small rural facilities; and

4. Loss of additional consulting and "value added" services to facilities, based on dropping Part B services.

#7: Meaningful Consultation with Affected Parties:

Realistic reforms will require a continuing dialogue among the affected parties. Providers, suppliers and beneficiaries are the experts and they must have a meaningful voice in designing and implementing reforms. A technical advisory panel, separate and distinct from those organized to evaluate hospital and physician payment reforms, must be empowered and assigned specific consultation activities.

#8: Streamlining of Program Requirements:

The complexity of current law stifles innovation and program efficiencies. Removing outdated requirements, such as the "transfer agreement" that require facilities to contract with hospitals for the provision of respiratory and medical diagnostic services, would improve market competition and reduce costs. We also support the elimination of the three-day stay requirement as academic studies and private sector approaches question the necessity for mandating a three-day prior hospitalization requirement for certain medical diagnoses.

#9: Support for Future Payment Changes:

NASL strongly supports the authorization of expanded data collection and research activities. Timely, accurate and relevant data is needed to support proposed changes and to plan for future program changes. Attention must be given to developing a realistic SNF market basket which expands the current nursing based index to account for a broader array of included SNF services. Measures of patient acuity must be perfected. Actions must be taken to better define "care episodes." Linkages across post-acute services must be better examined and defined. The Secretary should be encouraged to explore alternative post-acute payment approaches and to bring her plans back to the Congress for oversight and approval. However, we oppose any effort to bundle the post acute care payment into the hospital DRG. Finally, we applaud previous Congressional rejection of granting HCFA competitive bidding authority. These proposals will lead to discounted, low-quality health care services.

Summary:

The members of NASL support reasonable payment reform that encourages greater efficiency in providing services to seniors in the skilled nursing home. Seniors need appropriate services. We need clear and concise rules. We are ready to assist you with these issues so that constructive Medicare reforms can occur this Congress.

NALTH NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
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The National Association of Long Term Hospitals (hereafter "NALTH") is pleased to present this statement for the public record with respect to the Committee's hearing on Medicare post acute payment policies. NALTH has approximately forty-five member hospitals located across the United States. NALTH's membership includes long term hospitals and a range of not-for-profit, as well as investor-owned hospitals. A substantial portion of NALTH member hospitals have continuously served the catastrophically ill population which constitutes the long term hospital patient population since prior to the inception of the Medicare program in 1965.

At the public hearing on April 9, 1997, Chairman Roth's introductory comments indicated there was a need to control the growth of all PPS exempt providers and to establish prospective payment systems. NALTH agrees with these goals. NALTH believes it is important for Congress to be mindful that a substantial segment of long term hospitals receive inadequate reimbursement due to inequities created by the TEFRA system of reimbursement. Long term hospitals with many years of services in the Medicare program likely have distorted TEFRA base years and do not receive payment which is sufficient to defray the cost of providing medically necessary services to program beneficiaries and to pay for the extraordinary cost of serving a significant medically indigent population. The TEFRA payment system does not contain a disproportionate share payment component which is a component of the short term hospitals prospective payment system. NALTH believes Congress should approach its task of reforming the Medicare payment system in a balanced way which will result in an equitable payment system which ultimately pays for patient resource use instead of hospital specific cost. For various reasons explained below, NALTH believes the President's proposal will create new inequities by instituting a new hospital specific cost based payment system with virtually no payment adjustments and, therefore, destined to become distorted and hence inequitable quickly. NALTH is in the process of developing a long term hospital prospective payment system which is of the type which should be considered for true payment reform. A long term hospital prospective payment system should be implemented by the year 2000. As interim measures NALTH has proposed a cost savings measure and TEFRA target rate restructuring which are included in Attachments "A" and "B" to this statement. These proposals directly address the concerns expressed by Senator Roth at the public hearing on this issue.

A summary of NALTH's recommendations to Congress are as follows:

1. The current TEFRA system should be discarded as soon as possible in favor of a long term hospital PPS. Our Association is developing such a system and expects to complete a long term hospital patient classification and payment system by the summer of 1998. NALTH will continue to meet with Congressional staff and HCFA as it develops the long term hospital PPS. We recommend that this year Congress enact legislation which would authorize the Secretary, after consulting with Congress, to adopt a long term hospital PPS in the year 2000. The Secretary should be required to report to Congress on her progress in establishing a long term hospital payment system on or before the commencement of 1999.

2. In the interim, Congress should not require a rebasing of TEFRA rates based on average costs, as has been proposed by the President. The use of average costs as a payment limit would produce an invalid patient classification system and reward hospitals which change the type of patients they serve to minimize resource use after the establishment of the new base year period. It is well documented that long term hospitals serve a heterogeneous mix of patients. The use of an average would erroneously assume that long term hospitals serve patients who require similar medical resources. For the same reasons, as well as the technical considerations contained in Attachment "C" to this statement, the 130% limitation on target rates of new hospitals contained in Section 8402(b) of last the year's Balanced Budget Act should not be adopted.

3. Until a long term care hospital PPS is implemented, cost savings may be achieved by imposing a national limit on the difference between allowable costs and TEFRA ceiling amounts. The national ceiling would have two functions -- first, to place a limit on incentive payments for new hospitals and, second, to reduce the rate of increase in target ceilings for existing long term hospitals with incentive payments.

4. Long term hospitals with distorted base years, like the Hospital for Special Care, which have been significantly under reimbursed should be allowed to update their base year

if they serve a significant disproportionate share population of 25% or more.

5. Congress should continue the minimal payment protections it has established for PPS exempt hospitals whose allowable costs exceed their TEFRA limit. This issue primarily affects long term hospitals with older target rates. At the present time, the Medicare program shares the loss incurred by these hospitals up to 10% of an individual long term hospital's target amount. Currently, long term hospitals with old base years are also allowed a full market update. This provision of the Act expires in 1997 and should be continued. The President's proposal would eliminate both of these necessary safeguards.

6. If Congress chooses to restructure the TEFRA system prior to adoption of a long term hospital PPS, NALTH proposes the following rules be established for long term hospitals in the future.

- Limit the number of Medicare discharges that would qualify for incentive payments to a base year ratio of hospital discharges to total hospital licensed bed capacity. This provision would eliminate the incentive of the current TEFRA system which allows "new" long term hospitals to maximize TEFRA target payment by increasing Medicare discharges after the establishment of a base year.

- Limit allowance of base year administrative costs to a grouping of long term hospitals by bed size, related party status, area wages and other appropriate hospital characteristics.

- As part of payment restructuring allow long term hospitals which have experienced two consecutive years of losses to be paid allowable costs for a two year period and to establish a new TEFRA base year subject to the above "new" hospital rules.

7. NALTH believes strongly that Congress should grandfather long term hospitals which are co-located with other hospitals as of September 30. 1995, from special conditions of Medicare participation which the Secretary has applied to these hospitals.

Medicare Payment Issues

Long term hospitals present unique payment issues which do not affect other classes of PPS-exempt hospitals. As PROPAC has noted on virtually an annual basis, long term hospitals serve a diverse patient population. Because long term hospitals provide patients with markedly diverse programs of care, the resources used to render patient care differ significantly between hospitals. Long term hospitals differ from rehabilitation hospitals and units which must serve patients who fall within ten standardized rehabilitation diagnoses. The President's proposal does not reflect the differences in resources used by long term hospitals and will not work well for long term hospitals for various reasons.

- First, the President's proposal would rebase all long term hospitals with a national ceiling and floor of 150% and 70% of national average cost. The use of a measure of central tendency such as an average is inappropriate for long term hospitals because, unlike other classes of PPS exempt hospitals, long term hospitals do not serve a homogeneous case mix. The payment limitations proposed by the President would provide an economic incentive to dismantle treatment programs for patients with complex medical care needs. These patients would become likely candidates for repeat PPS hospital and SNF admissions.

- Second, the President's proposal would eliminate incentive payments which are now available for PPS exempt hospitals which have reduced the growth of operating costs per discharge below levels authorized by Congressionally approved update factors. Incentive payments constitute a surrogate payment for the disproportionate share population which is uniquely cared for by long term hospitals. Since a disproportionate share methodology does not exist for PPS exempt hospitals, elimination of incentive payments would de facto penalize long term hospitals for continuing to serve catastrophically ill patients who may also be dually eligible for Medicare and Medicaid benefits.

- Third, the President's proposal would eliminate adjustments to TEFRA rates unless hospital costs exceed TEFRA limits by 150%. This provision would magnify one of the acknowledged flaws of the TEFRA system by insuring that the new base year becomes quickly distorted due to changes in patient severity, hospital technology and other factors.

The Committee is urged to consider a different approach to long term hospital payment policy. NALTH proposes that existing long term hospitals, on a selective one-time basis, be allowed a new base year. Long term hospitals which have experienced two or more years of Medicare allowable costs exceeding its TEFRA payment limit, and which serves over a 25% disproportionate share population would be rebased under this proposal. So too would a long term hospital which is located in a state that provides no Medicaid coverage to Medicare beneficiaries who have exhausted their Medicare day limit and meet the other tests of this proposal. A complete description of this new base year proposal is included as Attachment "D" to my testimony.

We believe approximately 10 - 15 long term hospitals will qualify for rebasing under this proposal. This measure will partially address the inequity of the current TEFRA payment system for hospitals with distorted base years. Hospitals with distorted base years serve catastrophically ill Medicare beneficiaries and have no real opportunity to cross subsidize Medicare losses. It is important to note that PROPAC has found that the average Medicare payment to cost ratio is lower for long term hospitals with older or distorted base years than any of other class of hospitals, including short term PPS hospitals. Many of these hospitals treat patients who require the same intensive hospital care as "new" hospitals, but do so for a lower average cost. Last year, PROPAC reported that for "older" long term hospitals, Medicare payments covered only 85% of operating costs. It is NALTH's expectation that the Medicare cost saving proposal which we have presented to the Committee will more than offset the cost of rebasing these hospitals.

Establishment of a Long Term Hospital Prospective Payment System

PROPAC has on an annual basis recommended the development of a prospective payment system for long term care hospitals. The National Association of Long Term Hospitals agrees with this recommendation and believes there is good reason to establish a long term hospital PPS. There is, perhaps, universal agreement

among policy makers that the current TEFRA payment system has become inequitable and inefficient. To restore equity to long term hospital payment policy the National Association of Long Term Hospitals has engaged the Lewin Group to establish a PPS for long term care hospitals. The first phase of this project involved a feasibility study including an in depth review of whether the current short term, acute hospital PPS system could be used for long term care hospitals. The feasibility study determined that it could not because of large differences between acute and long term hospitals in length of stay. This research has been provided to the staff of this Committee as well as to PROPAC and HCFA. The Lewin Group did, however, find that there were promising correlations between DRGs, case mix and resource use by long term hospital patients. Current research being conducted by Lewin includes a reconfiguration of DRGs to reflect the variation in case mix across long term hospitals as well as a reweighting of DRGs to reflect differences in length of stay and resources used. NALTH anticipates presenting additional work on long term hospital PPS to the Staff of this Committee, HCFA and PROPAC in the near future. At that time we hope to have completed substantial work on the development of a patient classification system for long term hospitals. The current work plan for the study calls for the completion of a long term hospital PPS by June of 1998. It is anticipated, the new long term hospital PPS will include a patient classification system and a payment system complete with outlier and disproportionate share payment methodologies. It is the National Association of Long Term Hospital's intention to establish a workable PPS system which is budget neutral.

Alternative Cost Savings Proposal

Attachment "A" to this statement contains cost savings measures which the National Association of Long Term Hospitals believes Congress should consider in lieu of the President's cost savings initiatives. In making this proposal, the objectives of the Association are: (1) to provide financing for the selective rebasing of long term hospitals which meet a disproportionate share test; (2) to preserve the current payment system for long term hospitals which are currently certified until a long term hospital PPS is implemented; and (3) to create financial incentives to slow the growth of long term hospitals. Cost savings would be achieved by establishing a national ceiling on the difference between Medicare allowable costs and target rate ceilings. This difference between TEFRA ceiling amounts and allowable costs is currently used to calculate incentive payments

for so-called "winner" hospitals under the TEFRA payment system. It is important to understand that TEFRA ceiling amounts for so-called "winner" hospitals are not actually expended by the Medicare program on patient care, but are included within projected spending by the Congressional Budget Office. The cost savings proposal would reduce the difference between allowable costs and TEFRA limits to establish a national ceiling on both TEFRA ceilings and incentive payments for long term hospitals established in the future. The national ceiling would be established in a one time calculation at the 75th percentile of the difference between allowable costs and TEFRA ceilings for long term hospitals with incentive payments. As additional cost savings, long term hospitals with incentive payments would, in a graduated fashion, experience a reduction in update factors.

Grandfather Long Term Hospitals Co-Located with Other Hospitals as of September 30, 1995 and Make Certain Other Corrective Changes

HCFA has adopted regulations directed at long term hospitals which are co-located with other hospitals. The regulations set forth requirements to assure a long term hospital is independent from its "host" hospital in terms of the delivery of patient care services. The National Association of Long Term Hospitals does not object to the policy objective of these regulations. One aspect of the regulations, however, has proved to be inequitable. The regulations require that the two hospitals have independent governing bodies. HCFA's current interpretation of this regulation has had the following inequitable consequences. A long term hospital which is part of a state hospital system and located on the same campus as a state university teaching hospital is in technical violation of the regulation because local law requires that its governing body be a public hospital authority. Long term hospitals owned by various religious organizations and not-for-profit hospital parent organizations must be able to appoint and remove subsidiary hospital Board members and otherwise act as a parent organization in order to discharge their fiduciary duties. HCFA staff has recently rendered opinions, orally, that parent organizations may not exercise authority to appoint and remove Board members of subsidiary long term hospitals which are co-located with other hospitals on the same campus. A number of long term hospitals owned by states and not-for-profit organizations did not have notice of this regulation when they established their long term care hospitals. Accordingly, we believe it is appropriate to provide for a grandfathering of these hospitals from the

regulation. We further believe it is important for the Boards of Directors of new long term hospitals to be able to adequately discharge their fiduciary duties through the appointment and removal of Board members of their corporate subsidiaries. The Congressional Budget office has estimated the grandfathering provision would increase Medicare outlays by $3 million in FY 1997 and by less than $.5 million in 1998.

Opposition to Section 11279 - Development of an Integrated Payment System for Post Acute Services

The National Association of Long Term Hospitals believes that good reasons exist to oppose this provision of the President's proposal. This proposal would essentially "carve out" the entire post acute spectrum of care for a single prospective payment. This type of payment system would create economic incentives which do not appear to be in the best interest of program beneficiaries. A large "post acute" payment would create a powerful incentive to discharge patients even earlier from the fixed price PPS hospital setting. The establishment of such a payment system would require a patient classification system which would measure resource use from the home health care setting to the hospital level, including long term and rehabilitation hospitals. It may well be impossible to establish such a patient classification system. It should be remembered that HCFA has been attempting to establish a case mix based classification system for home health agencies for approximately 12 years. It would seem extraordinary that HCFA would be able to establish a valid payment system for a much wider spectrum of services in a few years. In connection with this issue, the National Association of Long Term Hospitals invites the Committee's attention to the perverse consequence that such an integrated payment system could have on beneficiary benefits. An integrated payment system premised on being "site neutral" is anything but "site neutral" from the beneficiary's perspective. Benefit days are determined based upon the site that a patient is treated. That is, there is a different benefit package available to patients treated in hospitals as opposed to skilled nursing facilities. Additionally, different co-insurance and deductible amounts apply depending on the classification of the site, hospital, SNF, or home health agency, where a Medicare beneficiary receives services. The incentive under an integrated "site neutral" payment system would be for patients to be shifted to the lowest level of care in order to trigger co-insurance payment amounts and to exhaust covered days as quickly as possible. This is a particularly serious problem for the extreme

outlier population which is treated by long term care hospitals. We understand that this very problem has presented itself in the Medicare Managed Care Program. The current analogy for an integrated "site neutral" payment system is indeed the current Medicare managed care payment system. Research on this issue has noted the potential shifting of patients to an inappropriately low level of care, for example, to a SNF, to cause the exhaustion of Medicare benefits and the subsequent shifting of patient financial risk to other payors such as the Medicaid Program. See Attachment "E" hereto. Finally, Section 11279 calls upon Congress to abdicate its traditional oversight authority to review and approve payment systems. Accordingly, it should be rejected on policy grounds.

Opposition to Establishment of Two Classes of Long Term Care Hospitals

The National Association of Long Term Hospitals opposes the establishment of two classes of long term hospitals, one for so-called "chronic" and one for so-called "acute" long term care hospitals. What is needed is an appropriate patient classification system to measure and fairly pay for intensity of patient care and resource use. In order for any patient to be admitted to a long term care hospital, the patient must meet hospital level utilization review criteria. The Health Care Financing Administration has approved explicit long term hospital admission and continued stay screening criteria for Provider Review Organizations operating in two states. The establishment of two classes of long term hospitals for payment purposes would simply result in a new class of high cost TEFRA hospitals. We assume Congress would not endorse a policy which would encourage the creation of a large number of hospitals which only perform heart transplants, because such hospitals would have extremely high costs. Heart transplants are usually performed in hospitals which also provide less intensive and, therefore, less costly, hospital services. Most NALTH members provide both high intensity services such as ventilator care and lower intensity services such as wound care, which reduces overall hospital costs.

If the Committee has any questions concerning this statement, please contact NALTH's General Counsel, Edward D. Kalman at (617) 227-7660.

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ATTACHMENT A

NALTH COST SAVING PROPOSAL

March 18, 1997

I. Establishment of National Target Rate Ceiling.

- Savings are achieved:
    - By imposing a national limit on the amount LTH TEFRA ceiling amounts may exceed allowable cost.

Using the national TEFRA ceiling to limit the rate of growth of target amounts for existing LTHs and to limit target amounts for "new" LTHs.

- By establishing a national LTH target rate limit which would be calculated once, using the most recent cost reporting data for LTHs with incentive payments. Cost reports for LTHs whose costs exceed target ceiling amounts would not be used in the calculation of the national target limit.

- The national target rate ceiling would be calculated as follows and as set forth in the Attachment hereto:

    - For each LTH with an incentive payment, net program payments, composed of allowable program costs and incentive payments, would be subtracted from target rate ceiling amounts. This calculation will produce "authorized but not spent amounts" for each LTH. A sample calculation of authorized but not spent amounts is contained in column (e) of the Attachment hereto.

- The national LTH target rate limit would be set at the 75th percentile of "authorized but not spent amounts." Based on 1993 Medicare cost reports, NALTH has estimated the national limit on TEFRA ceilings under this method to be $8008.50.

II. Application of the LTH National Target Rate Limit.

- LTH TEFRA ceiling amounts would be reduced where authorized spending for an individual LTH exceeded the national limit as illustrated in column (h) of the Attachment hereto.

- It is proposed that LTHs certified for program participation at the time of enactment of the cost savings provision (i.e. current LTHs) would have their incentive payments calculated as if no national target rate limit was imposed.

- For "new" LTHs, the LTH national ceiling on target rate amounts would act as a ceiling on both allowable cost and incentive payments.

- The LTH national target rate ceiling would be subject to any PPS update authorized by Congress.

- For all LTHs whose target limits exceeded the national LTH TEFRA limit, TEFRA ceiling amounts would be reduced to the national limit as illustrated in column (h) of the Attachment hereto. In the example contained in the Attachment, authorized spending for the two hypothetical hospitals would be reduced 15% from $70,000 to $59,500 (column (g)÷(a)).

- Where a LTH target ceiling is reduced by the national limit, update amounts for future years would be applied to a lower target rate ceiling thereby reducing the growth of target amounts. For example, assuming a 2% update factor, the rate of growth in the target ceiling of Hospital "B", illustrated in the Attachment, would be reduced from $800 (2% of $40,000) to $600 (2% of $30,000), a 25% decrease.

III. Additional Savings Through Reduction in Up-Date Factor.

After imposition of the national limit on target amounts additional cost savings would be achieved by reducing the up-date factor in a graduated manner so that LTHs with the highest incentive payments would receive the greatest reduction as follows:

Percentile of Incentive Payments	Reductions in Up-date Factor
76% - 100%	75%
50% - 75%	50%
25% - 49%	25%
0% - 24%	0%

Note on CBO Scoring.

Currently, the CBO scores a reduction in the up-date factor as a major cost savings measure. A reduction in the update factor for TEFRA hospitals with incentive payments has only a marginal effect on TEFRA ceiling amounts and Medicare expenditures. An actual reduction of TEFRA amounts for LTHs should result in more significant cost savings because it directly reduces authorized spending.

nalth160.smg

Cost Savings Proposal
National Association of Long Term Hospitals

	(a) Authorized Spending (TEFRA) Ceilings)	(b) Actual Cost	(c) Incentive Payment	(d) Net Program Payments (b) + (c)	(e) Authorized But Not Spent (a) - (d)	(f) National Limit[1]	(g) Reduction in Authorized Spending (e) - (f)	(h) Adjusted TEFRA Ceilings (a) - (g)
Hospital A	$30,000	$20,000	$1,500	$21,500	$8,500	$8,000	$ 500	$29,500
Hospital B	$40,000	$20,000	$2,000	$22,000	$18,000	$8,000	$10,000	$30,000
	$70,000	$40,000	$3,500	$43,500	$26,500		$10,500	$59,500

(----------Current Law----------)

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[1] Based on NALTH's review of FY 1993 cost reports a national LTH target rate limit set at the 75th percentile of "authorized but not spent amounts" is estimated to be $8,008.50.

ATTACHMENT B

NALTH NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
150 York Street, Stoughton, Massachusetts 02072 (617) 344-0600 Boston line (617) 364-4850 FAX (617) 344-0125

NALTH TEFRA RESTRUCTURING PROPOSAL (3/28/97)

- For LTHs certified in the future, incentive payments would be limited to the ratio of hospital discharges to total licensed bed capacity in the base period. The same ratio would apply to any future change in licensed bed capacity. This provision would limit the number of patient discharges for which an incentive payment could be made to growing TEFRA rates with low base year discharges.

- Base Year Administrative and General ("A & G") A & G for new hospitals would be limited to average A & G cost for the applicable group. For the purpose of determining average A & G costs, cost reports for hospitals with base years commencing on and after FY 1993 would be used. The applicable class of long term hospitals would be determined by bed size and would be in increments of 0 to 50, 50 to 100, and over 100 beds. Hospitals which belong to multiple hospital chains, which are related parties, would form their own grouping. Direct patient care costs would be handled in the manner that they are currently included under the TEFRA system.

- Long term hospitals who were TEFRA "losers" and who were certified before 1994 which had two consecutive years of TEFRA loses would be entitled to allowance of administrative cost up to the limit noted above for the particular class of LTH and would be entitled to have direct patient care cost paid on a reasonable cost basis. The Secretary would be allowed to establish a new base year period using a blend of two years of reimbursement on this basis.

- The Secretary would be authorized to implement a LTH PPS no later than the federal fiscal year 2000.

ATTACHMENT C

Technical Issues Relating to Section 8402(b) of the Balanced Budget Act of 1995.

- Subparagraph (ii) of Section 8402(b) is ambiguous whether the proposed 130% TEFRA payment limit applies to LTHs which were in the process of establishing a target amount and, therefore, were on a cost basis on October 1, 1995. If Congress is to pursue a 130% or similar target rate limit, NALTH believes this language should be clarified to exclude hospitals which were assigned a provider number of a non-subsection (d) (i.e. non-PPS) hospital until some date subsequent to enactment of this provision. In the absence of this clarification, the TEFRA limit might be applied retroactively to hospitals which incurred cost and established programs without notice of the 130% payment limitation. NALTH has proposed clarifying language concerning this issue which is included in Attachment 3.

- There is no provision to update the 130% payment limit from a 1991 target rate payment amount of approximately $16,160 per patient discharge. At the same time, under subparagraph (b)(i), a moving TEFRA rate floor would be established at 50% of the national mean target amounts for each fiscal year. If the 130% TEFRA ceiling is fixed at 1991 levels, the 50% TEFRA floor, which is to be recalculated annually, may at least theoretically exceed the national payment ceiling for new hospitals.

- Section 8402(b) would insert a new subsection (F) into Section 1886(b)(3) which would apply the 130% TEFRA rate payment limitation and 50% TEFRA payment rate floor to a "rehabilitation" hospital currently (or unit thereof)." Rehabilitation hospitals may not operate separate rehabilitation units, (see 42 C.F.R. §412.25(a)(l)(ii)), because a PPS excluded hospital may only be assigned one target amount per discharge. NALTH believes this language could be clarified to apply to rehabilitation hospitals and rehabilitation hospital units as defined by the Secretary. See 42 C.F.R. §412.23(b).

ATTACHMENT D

NATIONAL ASSOCIATION OF LONG TERM HOSPITALS
150 York Street, Stoughton, Massachusetts 02072 (617) 344-0600 Boston line (617) 364-4850 FAX (617) 344-0128

March, 1997

NALTH SELECTIVE OPTIONAL REBASING PROPOSAL

NALTH proposes to allow long term hospitals which meet a disproportionate share test and which have experienced two years of Medicare losses to elect to change their base year period to the hospital's fiscal year 1993. Under the proposal, a long term hospital must satisfy two requirements to qualify for rebasing. First, the hospital would be required to have Medicare losses (i.e. its Medicare costs exceed its TEFRA limit) for both fiscal years 1992 and 1993. Second, a hospital must demonstrate that 25% or more of its inpatient population was Medicaid and Medicare SSI eligible during the hospital's 1992 and 1993 fiscal years. This disproportionate share test would be calculated in the same manner as is currently the case for hospitals subject to the prospective payment system with the exception that a 25% disproportionate share standard would be used. A long term hospital located in a state which provides no inpatient benefits under the Medicaid program to a Medicare beneficiary who has exhausted the day limit imposed on Medicare benefits would be excused from meeting the disproportionate share test. NALTH understands that Texas may be the only state that excludes this class of individuals from Medicare coverage.

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ATTACHMENT E

SUBACUTE CARE
POLICY SYNTHESIS AND MARKET AREA ANALYSIS

Submitted to:
Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

Submitted by:
Lewin-VHI, Inc.

November 1, 1995

Lewin-VHI
A Value Health Company

VALUE HEALTH

care (expected to increase) and the form of care provided. But those we interviewed were troubled by what they currently saw of managed care.

For patients whose care is paid for on a per diem basis, managed care health plans have a strong incentive to discharge that patient as soon as possible to a lower level of care and, eventually, home. A number of acute care and subacute care providers expressed concern that these incentives are leading some managed care organizations to skimp on care and to discharge patients to the next level lower before the patient is ready. As discussed in Chapter Five, some institutional subacute providers believed they were being pressured to discharge some patients home before the patients were ready. Providers of home health services expressed their concern that some of the patients they now see at home require a level of care better provided in an institutional setting. In brief, in most of our interviews we were told that managed care organizations are generally focusing on little else but costs.

We also found that there is considerable confusion about the Medicare managed care benefit when beneficiaries are treated in subacute care settings, including concern regarding the following issues:

- Concerns that some Medicare managed care plans are attracting new enrollees with the promise of "unlimited" hospital coverage, but in practice are moving these beneficiaries from acute care hospitals to subacute SNFs early in a spell of illness and then cutting off coverage after a limited stay;[2]
- Concerns that Medicare beneficiaries are not made aware of their right to question a non-coverage decision by managed care plans;
- Concerns that Medicare managed care patients may be being placed in non-certified beds at subacute care facilities; and

[2] Some long-term hospitals have been particularly concerned with this issue. While we were not able to verify the extent to which the situation actually occurs, we did hear about it from a number of concerned providers. The issue is described as follows in a issue paper prepared by a long-term hospital.

"As one of their enrollment inducements to Medicare beneficiaries, Medicare managed care entities frequently market unlimited day coverage for inpatient hospital care. Beneficiaries who join these Medicare "at risk" HMOs understand they no longer need to purchase the 365 day hospital benefit which is mandated for Medigap policies. It is, however, the experience of most PPS-exempt hospitals, including long-term hospitals, that Medicare managed care contractors divert virtually all post-acute PPS-exempt hospital patients to subacute facilities. By doing so, Medicare managed care contractors require Medicare beneficiaries to prematurely exhaust their limited 100 day nursing facility benefit, not their unlimited hospital benefit.

This referral pattern is unique to Medicare managed care contracting and is not based on price considerations or patient outcomes. Thus, the current Medicare managed care program provides an economic incentive to place chronically ill and disabled Medicare beneficiaries that qualify for hospital level services in "subacute" SNFs. This will cause beneficiaries to prematurely exhaust their Medicare SNF day benefits and spend down to Medicaid status."

The National Association of Psychiatric Health Systems

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Statement of
Mark Covall
Executive Director
The National Association of Psychiatric Health Systems
For the Senate Finance Committee
Hearing on
Medicare Payment Policies for Post-Acute Care

April 9, 1997

MR. CHAIRMAN, I am pleased to write you today on behalf of the National Association of Psychiatric Health Systems for the Senate Finance Committee hearing on Medicare payment policies for post-acute care. NAPHS represents over 400 behavioral healthcare organizations that are committed to the delivery of responsive, accountable, and clinically effective treatment and prevention programs for people with mental and substance abuse disorders. Most of our members are free-standing psychiatric hospitals and psychiatric units within general hospitals. NAPHS members generally do not provide "post-acute" care; they serve as "primary" treatment settings for persons with psychiatric and addictive disorders.

I very much appreciate this opportunity to share our views on Medicare payments to psychiatric hospitals and units, which—along with rehabilitation and long-term care hospitals—are exempt from Medicare's Prospective Payment System (PPS). Specifically, I would like to address provisions in the President's fiscal year 1998 budget proposal regarding Medicare payments to psychiatric hospitals and units.

Background

PPS applies to all hospitals participating in the Medicare program; however, certain exemptions are specified by law. At present, five classes of specialty hospitals (psychiatric, children's, rehabilitation, cancer, and long-term) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are excluded from PPS. These hospitals fall under the TEFRA system (as mandated by the Tax Equity and Fiscal Responsibility Act of 1882), which reimburses under a system of limits based on reasonable and allowable costs. Psychiatric hospitals and units have remained excluded from PPS because psychiatric diagnoses do not adequately predict the cost of treatment, as research has consistently shown. The TEFRA system has been an effective method of controlling costs and Medicare expenditures without compromising quality of care.

Problems with the President's FY1998 Budget Proposal
While NAPHS fully supports congressional and administration efforts to reduce the federal deficit and ensure the viability of the Medicare program, we are concerned about several provisions in President Clinton's budget plan relating to Medicare payments to psychiatric hospitals and units. One is a proposal that calls for rebasing TEFRA payments to psychiatric hospitals and units (which means using a more recent base year to calculate payments to these facilities). Another provision would set ceilings and floors for these hospitals' and units' target rates. A third proposal would eliminate incentive payments for psychiatric hospitals and units.

NAPHS opposes the President's proposal to rebase TEFRA payments to psychiatric hospitals and units, because it would result in a redistribution of patient care funds from efficient providers to inefficient providers. Those hospitals that have successfully reduced patient costs and achieved an incentive bonus under TEFRA would lose under rebasing, while hospitals that have not succeeded in lowering costs would be rewarded. These are the wrong incentives. Also, TEFRA rebasing would increase regulation and micromanagement at a time when the Medicare program is moving toward more flexibility in the purchasing and provision of healthcare services for beneficiaries.

NAPHS opposes the President's proposal to set ceilings and floors for TEFRA payments to psychiatric hospitals and units, because such action is anti-competitive and ignores real differences in providers. Imposing a uniform, national ceiling, for instance, would unfairly treat all hospitals the same when their costs and patient populations are different. Capping payments would penalize those facilities that exceed the cap because of justifiable circumstances such as a more complex case mix, higher teaching costs, or higher costs associated with a particular geographic area, among other factors. A ceiling that does not adequately cover a hospital's costs may force some hospitals to reduce the types and level of services they offer, thereby limiting patient access to necessary and appropriate care.

NAPHS opposes eliminating incentive payments under the TEFRA payment system, because doing so would take away the only incentive TEFRA providers have to reduce their expenditures. (Under the current system, payments for inpatient operating costs are based on each provider's allowable costs per discharge or a target amount. A facility with operating costs below its limit—its target amount times the number of Medicare discharges—receives its costs plus an *incentive payment* equaling 50% of the difference between its costs and its limit or 5% of the limit, whichever is less.)

NAPHS supports maintaining the current TEFRA payment system for psychiatric facilities and units for the following reasons:

- The TEFRA system has effectively controlled costs. From 1992 to 1993, average psychiatric hospital operating costs per case declined by 4.7%, and average operating costs for psychiatric units in general hospitals declined by just under 1.0%. These costs are projected to remain stable or decline in the foreseeable future.

- The incentives in the TEFRA payment system to keep costs below the limit are much stronger today because of the increase in patient days delivered to Medicare patients. In many psychiatric hospitals, Medicare has become a much more significant payer than

in the past; consequently, there is strong pressure for TEFRA facilities not to exceed the limit.

- As Congress intended, the current system rewards cost-efficient behavior and penalizes inefficient hospitals.

- TEFRA is relatively simple to administer, and it does not require the accumulation and maintenance of complex data bases.

- Prior to OBRA '90, the design of TEFRA was challenged because it disadvantaged some providers due to disparities in TEFRA limits. However, the TEFRA reforms included in OBRA '90 substantially solved several basic problems. These reforms included allowing TEFRA facilities and units to receive 50% of their losses up to a maximum of 110% of their limits. In addition, there was some attempt to streamline the exception and adjustment process, although problems still exist, and rebasing was allowed on a case-by-case basis.

- In addition to the OBRA '90 changes, OBRA '93 legislation established a differential update for TEFRA facilities that were over their limits with facilities over their limits by more than 10% receiving the full Medicare update.

NAPHS believes that any reductions proposed for PPS-exempt facilities and units should be *proportional* to the reductions proposed for PPS facilities, which the President's plan fails to do.

NAPHS would be pleased to work with you, Mr. Chairman, and the other members of the Committee to develop more equitable and appropriate solutions to reducing Medicare costs.

Thank you for this opportunity to present our views on the President's proposed FY1998 budget as it relates to Medicare payments to psychiatric hospitals and units.

NATIONAL SUBACUTE CARE ASSOCIATION

MEDICARE SKILLED NURSING FACILITY PAYMENT AND REIMBURSEMENT

Medicare Savings and Reform

The Clinton Administration and the United States Congress are presented with a unique opportunity to reduce the growth of Medicare expenditures by adopting market-oriented efficiencies that are attainable through a prospective payment system based on *episodes* of patient treatment--*without sacrificing access to and quality of healthcare.*

A Transitional System Towards an Episodic PPS . . .

While NSCA strongly endorses an episodic, site-neutral prospective payment system (PPS) for skilled nursing facility (SNF) care, we recognize that the Administration's pending proposal for a PPS can offer a necessary transition to a soundly-developed episodic based system. NSCA urges implementation of such a transition payment system for SNF care beginning in FY 99 (October 1, 1998). Our transitional payment proposal is attached to this document, and would call for payments for routine and ancillary costs for each provider to be capped on a combined basis using the filed 1996 cost reports with exceptions.

Medical Incentives . . . and Reducing Medicare Growth . . .

NSCA urgently emphasizes that an episodic-based PPS focused on the patient's medical condition and severity of illness and ancillary requirements, rather than on per diem and/or provider licensure type, would incentivize providers to place patients in the most medically-appropriate setting *without distorting that decision with payment incentives.* An episodic system removes incentive for a provider to keep a patient longer than necessary and it does NOT limit patient access to the specific type of care they need. An episodic PPS can effect genuine, documented *reductions in the rate of growth of Medicare* and it can ensure patient access to and receipt of quality health care.

New Patient Case-Mix Information . . .

Important new patient case-mix data is emerging that supports the development of a PPS based upon episodes of care. Until this patient case-mix data is totally developed, however, NSCA urges the Congress and the Administration to support the implementation of a transitional payment system, such as that we have proposed and which other healthcare experts and organizations, such as the American Health Care Association (AHCA) have similarly endorsed.

A new patient case-mix patient classification and severity-indexed system applied to SNF patients will quantify important cost, resource allocations, and clinical outcomes emerging from subacute care. The further collection, analysis, and refinement of this new patient data will augment the integrity and effectiveness of a fully functioning episodic based PPS that Health Care Financing Administration (HCFA) can implement with confidence that payment and reimbursement of healthcare costs will be accurately and honestly made, without sacrificing access and quality of such care.

Administration Proposals . . .

NSCA supports the Administration proposal for an across the board reduction in the "market-basket" baseline, and we cautiously support consolidated billing for all SNF services to Part A patients while awaiting the outcome of internal industry and government discussions concerning consolidated billing to Medicare Part B patients. We urge the HCFA to fully explore with Congress the details and policy consequences involved in the actual operation of such consolidated billing, and we encourage a thorough review of these issues with providers before the final legislative language is drafted.

Fees and Accreditations . . .

NSCA opposes the imposition of new "user fees" for initial certifications under Medicare proposed for new facilities and we continue to support the use of HCFA-regulated professional accreditation organizations, such as JCAHO, for SNF survey and certification. JCAHO is currently used for hospitals which are more complex than nursing facilities/units. Additionally, the process uses a continuous quality improvement approach which is a more effective way to produce on-going, positive change in health care delivery than the current survey process being used. JCAHO requires the use of a certified outcome measurement and management system, and is more stringent in other areas such as credentialling, plant safety and equipment maintenance. Utilizing a professional accreditation organization would save as much as $110 million per year.

Congressional Oversight . . .

NSCA believes it is in the public interest for HCFA to collect and refine data necessary for the development of an integrated, post-acute care payment system. Specifically, we endorse the collection of data that would support an episodic PPS preceded by a transitional payment system. *We oppose granting the authority for the Secretary to implement any such system without Congressional oversight or approval.*

Medicare Reform Without Sacrifice of Healthcare Access and Quality . . .

Subacute care is intended to be quality, less costly rehabilitative and transitional care, achieving cost savings by providing such care in less expensive non-acute settings. The Medicare program can benefit by an episodic PPS system which recalibrates the most common post-acute care Diagnostic Regional Groupings (DRGs). Reduction in patient length-of-stays will garner saving for Medicare as well as for hospitals, and the availability of post-acute care will allow those efficiencies to be realized.

NSCA Position Summary . . .

In summary. NSCA offers its full support for legislative and regulatory initiatives that will create a Transitional SNF Payment and Reimbursement System that will evolve into an episodic, site-neutral Prospective Payment System that assures access to quality healthcare for all Americans and is based upon the emerging patient case-mix information so important to treating individuals on the basis of their verified medical condition rather than payment incentives.

NSCA

NATIONAL SUBACUTE CARE ASSOCIATION
ATTACHMENT TO TESTIMONY

TRANSITIONAL PAYMENT PROPOSALS

NSCA proposes the following conceptual proposals with the understanding that the dates and dollar amounts will be adjusted based on Congressional response and Congressional Budget Office estimates.

Establishment of a SNF Prospective Payment System

1. Require the Secretary of the Department of Health and Human Services to develop an episodic based prospective payment system for all skilled nursing facilities (freestanding and hospital-based) by 10/1/99. The Secretary shall establish performance based incentives for meeting discharge-to-home, length of stay and functional improvement targets. The system will be acuity based with multiple case mix categories to recognize the various levels of intensity of nursing and therapy sessions. In developing the PPS, the Secretary is to use the 1996 cost reports. This system is designed to create savings over the budget period.

Transitional Savings Until SNF PPS

2. **Interim Rate Combining Routine and Non-Routine Costs** - Until the prospective payment system for SNFs is implemented, an interim prospective system would be implemented beginning with fiscal year 1998. This system would call for payments for routine and ancillary costs for each provider to be capped on a combined basis using the filed 1996 cost reports with exceptions. The method for calculating the combined rate shall be a composite rate including routine services (SNF-participating cost divided by SNF-participating patient days) plus ancillary services, (Medicare ancillary cost divided by Medicare patient days) and including allowable exceptions. This rate will be the payment for each Medicare patient day. This composite rate for routing and ancillary costs would be updated by the hospital market basket minus some percentage in FY 1998 and by the full market basket from FY 1999-FY 2002 (if no permanent prospective payment system has been developed).

3. **Maintain Exceptions** - All skilled nursing providers will be included in the new prospective payment system on its implementation. Until that time new providers and providers who begin to develop atypical services in existing facilities must demonstrate to the intermediary and HCFA that atypical services were provided and the rate shall be adjusted to reflect the cost of providing atypical services. For providers just emerging from their new provider exemption period, for periods starting FY 1997, the provider must demonstrate to the intermediary and HCFA that atypical services were provided and the rate shall be adjusted to reflect the cost of providing atypical services. For providers

with exceptions granted for the cost reporting periods ending FY 1995, 1996 and 1997, their rate for FY 1998 shall be adjusted based on their 1997 approved exception.

4. **Reduce Exemption Period** - Reduce the new provider SNF exemption period by one year so that an exemption granted expires at the end of the provider's first cost reporting period beginning at least one year after the provider accepts its first patient. New providers would file for exceptions if they provide atypical services after the expiration of the exemption from the routine cost limits.

5. **Per Stay Limit for Intensive Needs Residents** - The Secretary, after consultation with appropriate agencies, outside experts, including skilled nursing facility experts, shall develop and publish by (date to be supplied late) a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

6. **Budget Neutrality Provision** - The Secretary shall adjust payments under paragraph 2 in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph 5. (This provision is intended to make number 5 budget neutral.)

7. **Reduce SNF capital cost reimbursement by 5%.**

Transitional Payment System Proposal Approved by the NSCA Board of Directors September 30, 1996

Position on Medicare Skilled Nursing Facility Payment and Reimbursement Approved by NSCA Board of Directors, March 12, 1997

Vencor, Inc.

Contact: Thomas L. Grissom
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Vencor is the nation's largest network of long term health care services. It owns and operates 38 long term hospitals and 325 nursing centers in 41 states and provides a complete spectrum of therapy and diagnostic services to an additional 2,000 nursing homes. It also provides home health and hospice services in some markets.

The Vencor mission is to provide essential medical services to the elderly population at the highest level of quality, with documented outcomes, and at the lowest cost to the nation's Medicare, Medicaid, and private insurance programs. Vencor believes the challenges of fiscal integrity and budgetary restraint present health providers with opportunities for developing and implementing new ways to deliver medical care.

Overview

Vencor believes that the Health Care Financing Administration has not been as accountable to Congressional directive nor as responsive to marketplace changes as it needs to be in the face of obvious demographic and financial trends. Much of our concern about the Administration's Medicare PPS-exempt proposals is based on the belief that HCFA has used neither its statutory authority to control program costs nor its intellectual and policy resources to redesign reimbursement systems that were considered "temporary" more than a decade ago.

Vencor also believes that many of the current proposals affecting PPS-exempt facilities are ill-conceived and punitive quick fixes meant to compensate for years of HCFA's inaction. Some of the proposals will create more problems than they solve, while others will exacerbate existing ones. If adopted, they will encourage HCFA to continue its reluctance to make the changes to the reimbursement system which are needed to reduce costs and ensure efficiencies.

Vencor will comment on specific proposals found in the Clinton Administration's Medicare savings plan and reference the proposals by section and number.

Section 11208 Payments to Hospitals Excluded from PPS

This section proposes radical rebasing of PPS-exempt hospital target amounts utilizing a national average, floors and ceilings to account for variability, and elimination of the incentive payment. This proposal transforms the TEFRA system without replacing it. The scheme reflects a set of values and beliefs short on facts and long on ideology. It ignores the 1996 recommendations of the Prospective Payment Advisory Commission and the advice of every provider in the PPS-exempt sector.

The current system is designed to reimburse a hospital or unit for its actual costs and reward it with an incentive payment if, over time, the hospital reduces its costs below its historic level established in the base year. When this occurs, the Medicare program obtains savings in its baseline and shares a fraction of the target amount with the hospital in the form of an incentive payment.

Congress gave the Secretary broad authority to adjust individual hospital target amounts whenever patient acuity, numbers of discharges, or changes in hospital services warranted a revision. It also provided for an exceptions process that enables hospitals to request full costs if operating conditions have changed since the base year target was established.

Vencor believes HCFA historically has not used its authority to manage this system and has taken few steps to control the formulaic calculation of targets for skilled nursing and rehabilitation units and long term hospitals. HCFA has also allowed an interim system to last for years without completing the work needed to replace it with a more efficient one.

The current Administration proposals are a mirror of what it recommended two years ago. However, in those two years, HCFA has done little to constrain costs or develop a new reimbursement system. And the industry remains vehemently opposed to HCFA's proposal because it is such a clumsy effort to cut costs without consideration of the consequences for beneficiaries and providers.

This Committee's staff has received other payment reform proposals which should be scored by the CBO and the results shared with industry providers. These approaches utilize differentiated updates, targeted emphasis on the spread between an individual hospital's costs and its target amount, and an improved process for determining how new or newer hospitals are reimbursed.

Vencor recommends that Congress reject the current rebasing proposal and preserve the incentive payment at least until a new post-acute payment system is fully implemented. Any rebasing proposal should account for variations in patient acuity and reduce the spread between hospital costs and target amounts.

Section 11207 Moratorium on New Long Term Care Hospital Exclusions

This proposal could be a reasonably effective control on unrestrained future growth in program costs for the transition period until a new payment system is devised as proposed in Section 11297. However, most providers do not have confidence in HCFA's ability to develop a new system in a timely manner and worry that the temporary restraint will become a permanent ban.

The proposal also allows HCFA to continue certifying long term "hospitals within hospitals". Vencor does not believe current statutory authority exists for HCFA to recognize these anomalies. The current HCFA regulations have not restrained their growth nor assured the integrity of their operations. HCFA has not demonstrated its ability to enforce these regulations. There is no evidence that "hospitals within hospitals" are needed for networking, managed care, or beneficiary convenience, as some providers and policymakers have asserted.

"Hospitals within hospitals", like Skilled Nursing and Rehabilitation units before them, have been established more to take advantage of inconsistencies and distortions in the Medicare reimbursement system (which HCFA was to have corrected 10 years ago) rather than improve patient outcomes or better serve beneficiaries.

Vencor recommends that Congress prohibit the certification of any future "hospitals within hospitals".

Section 11209 Reductions to Capital Payments for PPS-exempt Hospitals

Reductions in capital payments will impact PPS-exempt hospitals differently than PPS hospitals. The opportunities for accommodating these reductions with more private pay patients, updated DRG payments, or new hospital services is severely limited and fails to acknowledge their reliance on Medicare for all or most of its cost-based reimbursement.

Vencor recommends that the 15% reduction be phased in over three years at annual increments of five per cent.

Section 11206 Treatment of Transfer Cases

Vencor supports this provision as long as the discharging hospital payment is based on a formula that recognizes disproportionately higher front end costs during the hospital stay. Again, HCFA's reluctance to "level the playing field" or reduce the discontinuities between reimbursement systems and the provider facilities that bridge them, has become a costly problem and we support this effort to mitigate it until a new post-acute reimbursement system is designed per Section 11297.

Vencor recommends that discharges of patients from PPS hospitals to PPS-exempt facilities be treated as transfers for the purpose of adjusted per-diem reimbursement.

Section 11222 Prospective Payment for Skilled Nursing Facility Services

Vencor supports the development of a PPS system for skilled nursing care and believes the 1998 implementation is realistic and should be mandated by Congress. The system should be based on patient needs and adjusted for acuity.

A phase-in period, in which the move to a national rate is accomplished, should be accompanied by a freeze on Routine Cost Limits for new providers , a transition to regional rates, and collection of sufficient data to make the new payment system equitable for all providers, simple to administer, and cost efficient for the Medicare Trust Fund.

Vencor recommends that current limitations on the provision of therapeutic and diagnostic services in skilled nursing facilities remain in place until the new Prospective Payment System is implemented.

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